

# **Primary Behavioral Health Care Services**



## **Practice Manual**

**Version 2.0**  
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Produced for the  
Behavioral Health Optimization Program

Air Force Medical Operations Agency (AFMOA)  
Mental Health Division/SGHW  
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<b>Memoranda: Legal Observations and Consultant Endorsements .....</b>	<b>1</b>
<b>Chapter 1: Background and Rationale for Primary Behavioral Health Care .....</b>	<b>5</b>
<b>General Background .....</b>	<b>6</b>
RELEVANCE OF BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION .....	6
HISTORY OF USAF EFFORTS TOWARD INTEGRATED CARE.....	9
The Tinker Project (1997-1998).....	9
BHOP: Initial Implementation (2000-2006).....	10
BHOP: Continued Implementation (2006 - present).....	11
BHOP: Future Directions.....	12
THE BIG PICTURE: OVERVIEW OF POPULATION HEALTH CONCEPTS .....	12
APPLYING POPULATION HEALTH TO BEHAVIORAL HEALTH.....	14
Identify Your Population.....	15
Perform a Health Assessment and Needs Analysis.....	16
Target Your Resources to Priority Areas .....	16
Apply Evidence-based Interventions .....	16
Define Your Performance Measures.....	17
Evaluate and Modify .....	17
ABOUT THIS MANUAL .....	17
GENERAL DISCLAIMER.....	18
<b>Chapter 2: Primary Behavioral Health Treatment Philosophy, Program Goals, and Patient Goals.....</b>	<b>19</b>
PRIMARY BEHAVIORAL HEALTH CARE: TREATMENT PHILOSOPHY .....	20
PRIMARY BEHAVIORAL HEALTH CARE: KEY PRINCIPLES .....	21
PROGRAM GOALS.....	25
PATIENT/CLINICAL OUTCOME GOALS .....	26
Patient Goals .....	26
Clinical Goals.....	29
Service Quality Goals .....	29
Cost Goals.....	29
<b>Chapter 3: Primary Behavioral Health Services and Consultant Roles .....</b>	<b>30</b>
CATEGORIES OF PRIMARY BEHAVIORAL HEALTH SERVICES .....	31
Primary Care General Consultation Services.....	31
Population-based Integrated Care Services.....	32
Other Parameters of Primary Behavioral Health Care: Population, Customers, and Excluded Services .....	33
CONSULTANT ROLES.....	34
The Behavioral Health Consultant.....	34
Typical BHC Services in Primary Care .....	35
The Consultation/Liaison Psychiatrist (CLP) .....	36

## **Chapter 4: Service Procedures..... 38**

WAYS TO ACCESS BHC SERVICES .....	39
PCM Request for Consultation (Written or Verbal) .....	39
BHC Recapture of Specialty Mental Health Referrals.....	39
Self-Referral.....	39
FUTURE DIRECTIONS FOR BHC SERVICES.....	40
INDICATIONS FOR ALTERNATIVE PLACEMENT (SPECIALTY MENTAL HEALTH).....	41
PATIENTS PRESENTING WITH SUICIDAL IDEATION/HIGH INTEREST PATIENTS.....	42
ASSESSMENT INSTRUMENTS.....	50
DOCUMENTATION AND TREATMENT PLANNING .....	51
Initial Consultation Response .....	51
Follow-up Consultation Notes .....	52
DOCUMENTATION OF SENSITIVE ISSUES .....	53
PROVIDING FEEDBACK TO THE PCM.....	53
MISSED APPOINTMENTS.....	53
TERMINATION OF CONSULTATION SERVICES.....	54

## **Chapter 5: Administrative Procedures ..... 55**

ADMINISTRATIVE OVERVIEW .....	56
Medical Expense Performance Reporting System (MEPRS) Codes .....	56
ADS Coding.....	57
BHC SERVICE DEFINITIONS .....	57
The BHC Brief General Consultation Visit .....	57
The BHC Psychoeducational Class Visit.....	57
The BHC Continuity Consultation Visit.....	58
The Telephone Consultation Visit .....	58
SCHEDULING TEMPLATES.....	59
SCHEDULING STANDARDS.....	59
TECHNICIAN SUPPORT.....	60
DOCUMENTATION .....	60
INFORMED CONSENT AND COUNSELOR DISCLOSURE STATEMENTS.....	61
RECOMMENDED PROCESS FOR USING BHC INFORMATION SHEET .....	63
INTERVIEW SUGGESTIONS FOR INITIAL CONSULT .....	63
STAFFING GUIDELINES .....	64
PROGRAM EVALUATION.....	65
Customer-focused Evaluation .....	65
Quality Assurance .....	66
Clinical Outcome Evaluation.....	66
Practice Management Evaluation.....	66

## **Chapter 6: Recommendations for Clinical Practice ..... 67**

CLINICAL PRACTICE ISSUES: IS IT JUST A “ROSE BY ANOTHER NAME” .....	68
THE GESTALT OF PRIMARY CARE .....	68

IMPLEMENTING A GENERAL CONSULTATION PROGRAM: A PRACTITIONER’S GUIDE .....	69
Learn to Address Medication Issues .....	69
Get Your Foot in the Door .....	69
Act like a Guest.....	70
Be Flexible .....	70
See All Comers .....	70
Eliminate “Guesswork” .....	71
Privacy? There Is No Privacy.....	71
Networking with the Staff .....	71
Know Where PCMs Are, and When.....	71
Be Proactive, But Not Pushy.....	72
The Principle of Relentless Follow-up .....	72
Mimic the Work Pace .....	72
Be Available At All Times .....	73
Be a Visitor—and a Peer.....	73
Avoid Starting Your BHC Service in Internal Medicine .....	73
Ideas for Getting Started During the First Three Months of Consultation .....	73
WHAT ELSE YOU NEED TO KNOW BEFORE STARTING IN PRIMARY CARE.....	75
PHASE II: SKILL-BASED TRAINING IN CORE BHC COMPETENCIES .....	76
Structure of the BHC Skill Development Program.....	76
The BHC Training Core Competency Tool .....	77
PHASE III: CONTINUED MENTORING .....	78
BHC Credentialing.....	78

## References..... 79

### Figures

Figure 1. The Continuum of Collaborative Care .....	8
Figure 2. Traditional Physical and Mental Health Care.....	12
Figure 3. The Real Objective of Health Care.....	13
Figure 4: Cost of Interventions and Population Health.....	13
Figure 5: Population Health Management Model.....	15

### Tables

Table 1: Conceptual Distinctions of Primary vs. Specialty Behavioral Health Care Models.....	20
Table 2: Defining Characteristics of the Consultation vs. Specialty Treatment Models .....	24
Table 3: BHC Program Goals and Associated Service Delivery Features.....	26
Table 4: BHC Service Definitions .....	59
Table 5: Practice Management Metrics .....	66

**Memoranda: Legal  
Observations and Consultant  
Endorsements**



**DEPARTMENT OF THE AIR FORCE**  
**HEADQUARTERS UNITED STATES AIR FORCE**

5 April 2011

**UPDATE SYNOPSIS OF LEGAL OBSERVATIONS**  
**MEMORANDUM FOR RECORD**

**FROM:** Air Force Medical Operations Agency/SGHW  
Lackland-Kelly AFB, TX

**SUBJECT:** Synopsis of Legal Observations for Implementing Integrated Behavioral Health Care

1. A US Air Force legal review was obtained regarding the implementation of primary behavioral health care as described in this manual. A summary and interpretation of the legal observations and important considerations for the implementation of this model are provided below.
2. The proposed model of primary behavioral health care delivery appears to have significant support in the literature and strives to make mental health more easily available, less stigmatizing, and to allow for greater flexibility for the primary provider. However, this model of care is still relatively new in the health care world and, therefore, the appropriate "standard of care" is an evolving concept.
3. Traditional (written) informed consent is not required as long as the care offered by the Behavioral Health Consultant is consultative and in direct support of the PCM's care of the patient. The more the primary care provider has control over the actual delivery of patient care (i.e., diagnosis, treatment regimen, etc.), the greater the perception that the mental health provider's role is indeed merely that of a consultant.
4. BHCs will give all patients an information sheet detailing the role and scope of behavioral health services in primary care (standard is provided in Appendix 1 of this manual). A verbal disclosure statement (also detailed in this manual) should be a standard element of any initial patient contact as well. Most importantly, patients should be informed that discussions with the BHC may not be confidential and that the role of the BHC is to help the Primary Care Provider in making his/her own diagnosis and treatment plan.

5. A traditional (separate) mental health record will not be kept. All pertinent information will be documented and contained in the primary care (medical) record. Obviously, care should be taken with how sensitive information is documented. A modification to the language of AFI 44-109, paragraph 2 was recommended by this legal panel to reflect that conversations with BHCs in the primary care environment NOT be included in the protection. This will avoid separate documentation for all mental health involvement, understanding that the intent here is to treat this as a primary care issue and document in the primary care record.
6. The BHC's assessment and intervention plans will not include recommendations on specific types and dosages of psychopharmacology. BHCs can make recommendations about whether a patient may or may not be appropriate for pharmacological intervention. However, when a patient's presentation leads to a recommendation for pharmacological treatment, the BHC will inform the PCM who can then treat or refer to the most appropriate provider (specialty mental health).
7. Although a specific maximum number of BHC contacts does not exist, care and caution need to be taken in the number of assessments provided per patient under this model.
8. It is recommended that there exist a delineation of what types of mental health issues are appropriate under the umbrella of the Primary Care Provider and which ones should be directed to Specialty Mental Health (see section on [excluded services in manual](#)).
9. The literature notes the trend toward this concept of integrated health care. This Practice Manual is intended to serve as a guideline for all providers in the practice of integrated care within the AFMS, and providers should be prepared to follow the instructions therein carefully.

//SIGNED//

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**DEPARTMENT OF THE AIR FORCE  
UNITED STATES AIR FORCE MEDICAL OPERATIONS AGENCY  
LACKLAND - KELLY  
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19 January 2011

**MEMORANDUM FOR RECORD**

**FROM:** Mental Health Consultants to the AF/SG

**SUBJECT:** Joint Endorsement of the Primary Behavioral Health Care Services Practice Manual

1. The 1997 Behavioral Health Optimization Project (BHOP) at Tinker AFB marked the Air Force's initial test of integrating mental health providers into primary care clinics. Success of this demonstration led to implementation of the model at the three Air Force psychology residency programs and 10 additional selected MTFs in 2000.
2. In the past 10 years BHOP (now the Behavioral Health Optimization Program) has been increasingly implemented across the AFMS. Training in BHOP is included at the 4 Air Force Social Worker residencies. The Air Force continues to support site visits to AFMS MTFs in order to provide additional training, ensure fidelity to the model and facilitate the initiation and expansion of local BHOP services. BHOP has been a critical element in improving access of all beneficiaries to behavioral health services. Importantly, BHOP has also been a vital link in meeting the growing mental health challenges that have resulted from extended combat operations.
3. The current practice manual, which represents the first revision of BHOP practice guidelines since the inception of the program, updates guidance based on current research and the changing needs of the AFMS. It is our collective opinion that the information and guidance presented in this Practice Manual serve as a guide for the delivery of primary behavioral health care within the AFMS. All behavioral health commanders and providers should become familiar with the parameters of this model to ensure consistent and appropriate practice across the Air Force.

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# **Chapter 1: Background and Rationale for Primary Behavioral Health Care**

## GENERAL BACKGROUND

Change continues to sweep across the healthcare industry. Economic and political forces are reshaping the way the industry in the United States is delivering health and mental health services. Managed care is a harbinger of this fundamental shift, which will involve the re-engineering of health care (Strosahl, 1995, 1994a; Cummings, 1995). These forces also affect the Military Health System (MHS) and the Air Force Medical Service (AFMS). We must maintain a fit and ready force, respond to world crises, and yet remain in competition with our civilian competitors. To remain competitive, we must give all eligible beneficiaries a reason to join and stay with our managed care organization, TRICARE Prime. To do this, we must deliver the promised benefits of managing health and maintaining customer satisfaction, at a competitive cost.

Behavioral health care within the AFMS has historically been provided through several relatively separate service delivery systems. Primary care providers in Military Treatment Facilities (MTFs) provided much of the behavioral health intervention and medication for our beneficiaries. A smaller proportion of individuals with behavioral health problems were treated in military specialty mental health clinics. Limited access at many of our mental health clinics, however, resulted in a significant number of family member beneficiaries receiving specialty behavioral health treatment through the private sector.

The Behavioral Health Optimization Project, now known as the Behavioral Health Optimization Program (BHOP), initiated in 2000, sought to make substantial changes in the way the AFMS delivered behavioral health care. Through integrating mental health professionals (“behavioral health consultants,” or “BHCs”) into primary care using a consultative model, we aimed to address some of the dilemmas posed by the existing behavioral health service delivery system. It was hoped that integrated primary care could increase the quality and availability of behavioral health services available to all beneficiaries through our primary care clinics. More family members could receive behavioral health services through the MTFs rather than network providers, increasing patient satisfaction as well as recapturing cost from the private sector. Specialty behavioral health clinics would continue to provide care for those individuals with the greatest behavioral health need, providing efficient use of our behavioral health resources. Finally, it was hoped that positioning behavioral health care as a “routine” part of primary medical care through integrated services would reduce stigma associated with accessing behavioral health care.

## RELEVANCE OF BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

In the U.S., primary care providers see most individuals with behavioral health needs, such as psychological distress, physical conditions impacted by behavioral or emotional factors, noncompliance with treatment, or unhealthy lifestyles. That is, primary medical care is the *de facto* mental health system (Reiger et al., 1993). Research indicates that the general medical practitioner exclusively delivers half of all the formal mental health care in the United States (Narrow, Reiger, Rae, Manderscheid, & Locke, 1993). This represents a significant number of people, considering data from the Epidemiological Catchment Area Study and National Co-

Morbidity Study suggesting an annual incidence of mental disorders of around 18 percent (Reiger et al, 1993; Kessler, Burns, & Shapiro, 1993) and a more recent publication (Kessler, Chiu, Demler, & Walters, 2005) reporting that 26.6% of US adults age 18 and older will suffer from a mental health diagnosis within a given year. Within the AFMS, indications suggest that behavioral risk factors, stress related to family and work, post-deployment mental health problems, and symptoms of depression and other mental disorders continue to affect our population. Despite a high rate of occurrence, nearly half of all individuals with a diagnosable mental disorder seek no mental health care from *any* professional. However, 80 percent will visit their primary care manager (PCM) at least once a year (Narrow et al., 1993). This may be, in part, due to medical appointments made secondary to the physical symptoms of distress among patients with psychological or psychosocial concerns (Smith, Rost & Kashner, 1995). For example, a study of the ten most common physical complaints in primary care revealed that 85 percent end up with no diagnosable organic etiology during a three-year, follow-up period (Kroenke & Mangelsdorf, 1989). Besides a large number of patients who come to a primary care clinic at an Air Force MTF with unidentified psychological or psychosocial problems, we know that the MTF sees 100 percent of active duty personnel annually to accomplish a Preventive Health Assessment. Thus, primary care clinics serve as a crucial point of access to provide mental health services for the population.

While PCMs have been criticized for relatively poor recognition and treatment of psychological disorders, it is clear that they are providing both medical and behavioral interventions to their patients. Non-psychiatric PCMs prescribe approximately 75 percent of all psychotropic agents in this country (Beardsley, Gardocki, Larson, & Hidalgo, 1988). Further, studies of PCM/patient interactions indicate that PCMs frequently use behavioral interventions with their patients and encourage them to use behavioral strategies outside the confines of the PCM's office (Robinson et al., 1995; Robinson, 1995). The historical division of mind and body must give way to the reality that we cannot contain healthcare costs as long as we structure health and mental health care as separate and discrete enterprises. Such a great proportion of medical care is driven by psychological and psychosocial concerns that the ability of the two systems to contain utilization and costs depends on providing appropriate behavioral health services in the general medical setting (Friedman, Sobel, Myers, Caudill, & Benson, 1995). Taken as a whole, these findings make a compelling case for integrating behavioral interventions into the daily practices of PCMs. Not only is there significant potential for medical cost offsets, but also for increasing the quality of health care delivered by PCMs and other healthcare providers.

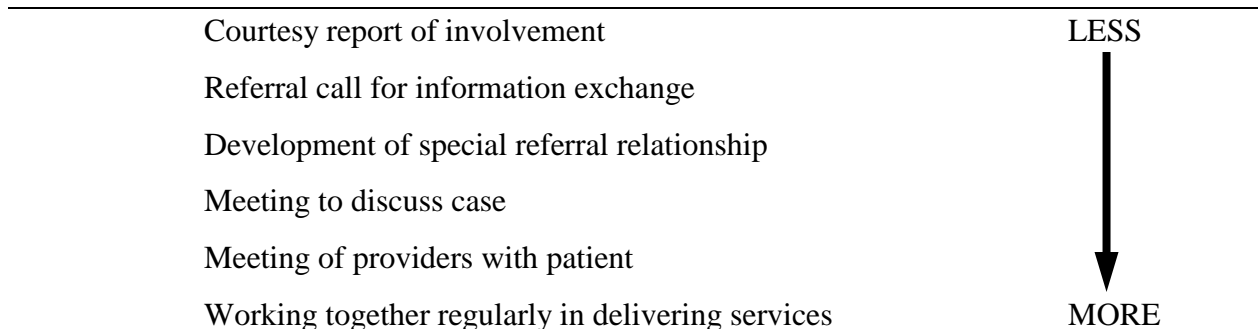
Researchers have examined the benefits of mental health programs integrated with primary care in a variety of practice settings, patient populations, and clinical modalities. Studies in the civilian sector have shown that integrating behavioral health (BH) services into primary care (PC) settings can improve patient satisfaction (e.g., Katon, et al., 1996), improve medical provider satisfaction (e.g., Katon, et al., 1995; Corney, 1986), decrease patient symptoms and increase functioning (Balestrieri, Williams, & Wilkinson, 1988; Moore, Von Korff, Cherkin, Saunder, & Lorig, 2000; Simon et al., 1998), and reduce healthcare costs (e.g., Blount, 1998; Chiles, Lambert, & Hatch, 1999). Patients who are referred to a BH provider integrated into their primary care clinic are much more likely to attend the appointment, compared to those who are referred to an off-site BH provider (90% versus 15%) (Strosahl, 1998). In integrated primary care clinics, outcomes with depressed patients consistently demonstrate improved patient satisfaction, clinical improvements, increased adherence to medications, decreased medical

utilization among “high utilizers,” and cost offsets (Brown & Schulberg, 1995). The common elements of successfully integrated programs appear to be full integration of mental health providers/services within the clinic, a structured program of treatment, an emphasis on follow-up care, and a focus on depression (Simon & Von Korff, 1997).

Within pilot sites for integrated clinics in the AFMS, surveys of patients and primary care providers have demonstrated high levels of satisfaction with integrated BH care (Runyan, Fonseca, & Hunter, 2003). Furthermore, the integrated services significantly increased access to BH care within the AFMS for military retirees and family members of active duty (Runyan et al., 2003). Research conducted within the AFMS has also highlighted the feasibility of managing insomnia (Goodie et al, 2009), reducing global distress (Cigrang et al, 2006) and obtaining clinically significant improvement in mental health symptoms and functioning (Bryan, Appolonio & Morrow, 2009) within the BHC model.

Integrated care can take many forms. At the broadest level, integrated care implies some combination of mental/behavioral health services and physical medicine; however, there is a continuum of collaboration. The most basic form of collaboration is simply a unidirectional sharing of information, in the form of a courtesy copy of a report from a mental health specialist back to a primary care provider. Although this is the lowest level of integration, even this degree of collaboration does not exist at many places. At the highest level of integration, providers work together regularly in delivering healthcare services to patients and function as a unified team (see Figure 1).

**Figure 1. The Continuum of Collaborative Care**



This latter form of integration has consistently demonstrated empirical support for both clinical and practice-management outcomes. This model of integration also rests within a population-based healthcare framework, which is precisely the emphasis of primary care service delivery in the AFMS. Although the AFMS reviewed and considered several models of integration for implementation, the only one that seemed applicable to the stated goals and objectives of this effort was the fully integrated model of primary behavioral health care. Thus, we selected this model for implementation, and it is the basis for all content and recommendations for practice.

We can simplify this population-based healthcare approach in the phrase, “Deliver the RIGHT CARE...by the RIGHT PEOPLE...at the RIGHT TIME.” To accomplish this, we must know who needs what services, and have the appropriate providers available to deliver that care. Without integrated care, our healthcare system is similar to most, in that we have no routine way

to detect the need for behavioral health interventions during routine care (i.e., when the patient is seen for a brief, symptom-focused appointment). Even when we appropriately identify behavioral health needs, services are typically not available within primary care to effectively address them. Furthermore, when providers refer individuals to specialty mental health care, most patients do not follow through on such recommendations. Among those who may follow through, care may not be available for all beneficiaries at the MTF, thereby creating an additional barrier to accessing mental health services. Thus, integrating behavioral health assessment and services into primary care settings is an excellent mechanism for both providing quality care and improving the health of the population. There is substantial evidence in both the civilian sector and at numerous USAF locations that integration can succeed. In the AFMS, our goals for integrating behavioral health providers into the primary care setting include:

- Improved recognition of behavioral health needs
- Improved collaborative care and management of patients with psychosocial issues in primary care
- An internal resource for primary care providers to help address a patient's psychosocial concerns or behavioral health issues, without referring them to a specialty mental health clinic
- Immediate access to behavioral health consultants, with rapid feedback
- Improved fit between the care patients seek in primary care and the services offered
- Prevention of more serious mental disorders through early recognition and intervention
- Triage into more intensive specialty mental health care by the behavioral health consultant
- Most importantly, delivering the RIGHT CARE...by the RIGHT PEOPLE...at the RIGHT TIME!

## **HISTORY OF USAF EFFORTS TOWARD INTEGRATED CARE**

### **The Tinker Project (1997-1998)**

We originally tested the concept of providing integrated care in the AFMS at Tinker Air Force Base, Oklahoma, during 1997-1998. We initiated the Tinker project to help ensure that integrating BH into primary care would work in the unique AFMS environment, and that it would have the same positive impact seen in the civilian sector. We felt that there were enough differences between civilian medical systems and the AFMS that a trial would be helpful.

A clinical health psychologist, a clinical social worker, and a mental health technician were assigned to the Family Practice Clinic at Tinker. The BH providers worked in a consultative model, and the project successfully proved the concept. For example, patients were highly satisfied with the behavioral health services provided. The physical health providers were also highly satisfied, and felt that the BH services had a substantial impact on both the clinic and their own delivery of patient care. Moreover, rates of medical care utilization among "high utilizers" decreased when behavioral health providers were involved with these patients. Beyond objective outcomes, we learned several lessons through this project. For example, how BH providers can fit into a very different work setting than a specialty mental health clinic, and how to practice differently. Most importantly, it helped confirm the desirability of *training* BH providers in

providing integrated care, to ensure consistency in service types, philosophies, and outcomes. In the civilian sector, virtually every organization that has successfully implemented the integration of mental health providers into primary care has provided comprehensive and extensive training. We launched the BHOP to fill this need in our system.

### **BHOP: Initial Implementation (2000-2006)**

BHOP originally encompassed several objectives to meet the overall goal of providing behavioral health consultation in primary care as a means of optimizing patient care. In general terms, we designed this project to effectively train mental health providers to provide collaborative care by integrating into primary care settings, using an established model. One of the first steps was to develop a set of service philosophies and program goals, along with practice guidelines for mental health providers. In May 2000, the Office for Prevention and Health Services Assessment (OPHSA) convened a working group of behavioral (psychology, psychiatry, social work) and physical health practitioners, with the goal of articulating guidelines and best practices for primary behavioral health care. The resulting set of recommendations and practice guidelines formed the basis of the original version of this manual (Office for Prevention and Health Services Assessment, 2000). The manual was intended to be a living document, revised as our knowledge and experience with integrated care in the AFMS grew. Beyond establishing practice guidelines for integrated care, the project evaluated the training and implementation processes of integrated care at pilot sites. We strategically selected the three psychology residency training sites (Andrews AFB, Wright Patterson AFB, and Lackland AFB) as pilot implementation sites. At least two providers (a combination of psychologists and social workers) at each site received intensive didactic and clinical training from Kirk Strosahl, Ph.D., and integrated into primary care. Several months following their initial training from Dr. Strosahl, the providers received another round of intensive training on “how to train” other providers in this model. This allowed them to become “expert trainers,” so they could train psychology residents, other staff members at their MTF, and providers from other MTFs.

As part of the project, experts trained providers from ten additional MTFs in the provision of integrated care. These additional providers traveled to a pilot site for five days, and received didactic and on-site clinical training from one of the expert trainers. MTF sites were selected based on provider interest, evidence of commander and leadership support for having behavioral health providers integrated into primary care, as well as facility size and major command affiliation.

We have systematically evaluated training and implementation of integrated care at our sites. Outcomes include provider workload, types of services provided and to whom, patient and provider satisfaction, and selected clinical outcomes. A survey of patients and providers across the initial BHOP pilot sites found that 97% of patients indicated they were “very satisfied” or “satisfied” with their care from the integrated BH provider. Of the primary care providers, 100% reported they would recommend other clinics initiate integrated BH care, and 95% indicated they believed the BH provider improved their ability to recognize and address BH problems (Runyan et al., 2003). Another study (Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006) evaluated 234 patients seen through BHOP in two AFMS primary care clinics and one AFMS internal medicine clinic. Results demonstrated significant reductions in levels of psychological distress from first to last BHOP appointment, supporting the effectiveness of this model of care for reducing mental health symptoms in a primary care setting. Access to BH care has been

improved through implementation of BHOP, and less than 10% of patients seen in BHOP have been referred to specialty mental health, suggesting that integrated BH providers are managing the needs of the majority of patients with BH problems within the primary care setting (Runyan et al., 2003).

The model and training approach used by the USAF has been described and disseminated to the broader mental health community in a number of publications (Dobmeyer, Rowan, Etherage, & Wilson, 2003; Hunter & Peterson, 2001; Rowan & Runyan, 2005). An innovative approach to expanding BHOP into USAF pediatric primary care settings also has been implemented and described in the literature (Etherage, 2005).

A collateral BHOP goal was to increase AFMS marketing of BHC services. This goal has been addressed through a number of strategies. Information has been disseminated through quarterly articles in the *Air Force Psychologist* (a publication of the Society of Air Force Psychologists), development of a BHOP section of the AFMS Knowledge Exchange website, a BHOP conference, and presentations at the annual USAF Behavioral Sciences Symposium. Information is also disseminated through the psychiatry, social work, and psychology consultants to the USAF Surgeon General and through the mentorship model of continued BHOP training. Marketing of services and timely dissemination of information continues as a BHOP priority.

A final early goal of the program was to develop clinical guidelines and resources for identifying and managing depression in primary care. Program staff provided consultation for the development of Clinical Practice Guidelines for the management of depression in primary care. Furthermore, Health Services Inspection (HSI) criteria now include standards related to assessment of suicide risk for patients who have been prescribed antidepressants.

### **BHOP: Continued Implementation (2006-present)**

The first several years of BHOP yielded substantial progress towards program implementation. BHOP training sites were firmly established at all three psychology residency training sites, and programs at the social work residency sites were being developed. Externship sites had been developed and additional mental health providers had been trained to implement BHOP. By April 2008, 55% of USAF bases had achieved integration of behavioral health into primary care.

Nevertheless, additional direction for BHOP was needed to address issues related to implementation, training, and sustainability. In 2006, a BHOP working group formed to address these developing needs. Members included the USAF psychology, social work, and psychiatry consultants to the USAF Surgeon General; the BHOP program manager; psychology and social work residency training directors; and experienced BHOP providers and trainers. Primary focus was given to strategies to maintain fidelity to the BHOP model over time. Recommendations addressed standardization and tailoring of training, revitalization of using a core competency approach for BHC evaluation, provision of BHOP supervision to unlicensed providers who have received initial BHOP training, and initiating a credential for practice in BHOP. A second major focus of the working group included recommendations regarding training, particularly externship training (i.e., training at an externship site for credentialed mental health providers, rather than training during a social work or psychology residency), as well as requirements to become a BHOP trainer. A third primary focus included developing recommendations regarding BHOP policy and revisions to the training tools (practice manual and appendices, training manual, educational videotapes, Knowledge Exchange website).



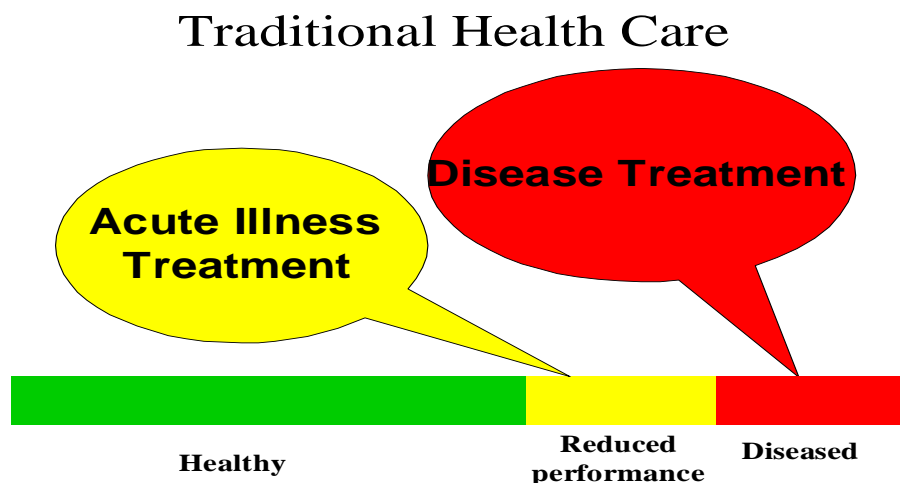
## **BHOP: Future Directions**

The present version of the manual (Version 2.0; 2011) is one primary product of the 2006 Working Group. It reflects current AFMS guidance for providing integrated care within the USAF and BHOP's intended role in the Patient Centered Medical Home. As we release this manual, BHOP has achieved many of its original goals and objectives, as discussed above. The AFMS continues to support this effort, both politically and through resource allocation. To that end, the future goals for BHOP include continued expansion of clinical training, to increase both the available pool of mentors in the AFMS for BHCs and the total number of providers who have received BHC clinical training. In addition, we hope to ensure uniform delivery in the AFMS through standardization of requirements for BHC mentors, continued emphasis on core competency evaluation, and the implementation of a credential requirement for BHOP practice. Finally, we plan to increase our analysis of specific BHOP outcomes, with an emphasis on population-level indicators of behavioral health outcomes and medical outcomes, PCM time and cost savings resulting from integrated services, and impact of integrated care on the medical use patterns of patients identified as high utilizers of medical services.

## **THE BIG PICTURE: OVERVIEW OF POPULATION HEALTH CONCEPTS**

Our current healthcare system focuses on chronic diseases and acute illness, and doesn't put adequate effort into health maintenance or sub-clinical diseases (see Figure 2). Mental health has operated largely with this same focus; that is, delivering services almost exclusively to the "sick." Population health seeks to re-define the objectives and application of healthcare delivery.

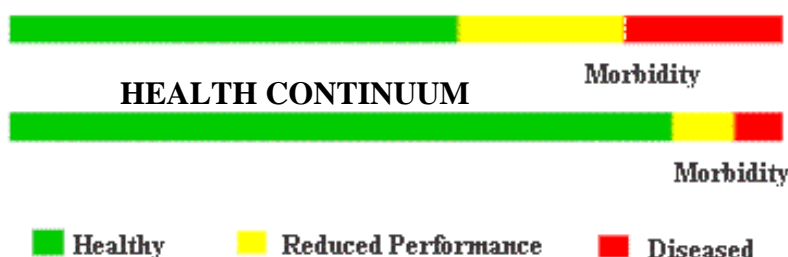
**Figure 2. Traditional Physical and Mental Health Care**



Population health focuses interventions on the entire population, in addition to those acutely in need of services. By shifting to a population focus, providers pay attention to both those who currently need care and those currently healthy, but who could benefit from some services to stay well longer. Most illness develops over time, but our healthcare system typically does not respond during the development of initial symptoms. The traditional approach is to wait until a disease process is evident before intervening. For most illness, impairment and reduced performance occur in the sub-clinical stages of a disease and precede the diagnosis. A population-health approach mandates earlier intervention, to reduce disability and increase quality of life (see Figure 3).

**Figure 3. The Real Objective of Health Care**

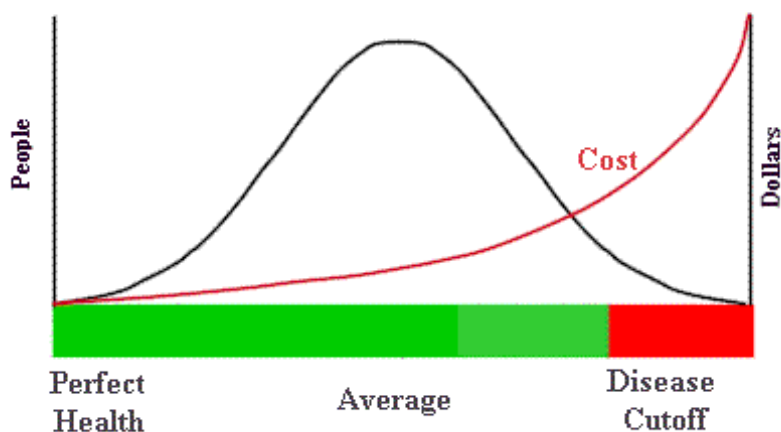
**Increasing Healthy Lifespan: Compression of Morbidity**



Although the nature and impact of population-health services vary, often the earlier we intervene, the more likely we are to reduce the intensity and cost of an intervention, and maximize its success. Figure 4 shows the relationship between the cost of interventions and the health of a population.

**Figure 4: Cost of Interventions and Population Health**

**Health and Disease Continuum in a Population, with Cost**



Starting with the healthiest part of the population, you would see a flat or very slowly rising cost line, from the left tail of the bell curve, through the majority of the population. It would begin rising in the small area on the right, where disease starts happening, but from there would head almost straight up. The sick and disabled consume almost all health dollars. So, from a cost perspective, only the small percentage that is sick and disabled is important. That is where we are spending all the money, and that is where we should focus cost-reduction programs, such as disease management. From this perspective, spending money on the larger, healthier population doesn't make sense. However, successfully reducing the cost of treating and managing disease only makes the system more efficient in dealing with the small numbers of sick and disabled. It does nothing for the large pipeline that keeps fueling this fire, and it has little effect on the population's health as a whole.

We need a practical and politically pragmatic combination of the two approaches. Disease management programs could free up resources by providing more efficient care of the sick and disabled. We could invest these resources, in turn, in prevention programs. A healthier population would eventually shrink the percentage with disease and disability, thus decreasing the costs even further. Theoretically, this approach would delay the onset of disease and limit disability until the last possible moment. People would stay as healthy as possible until the eventuality of death occurs, sometimes called "compression of morbidity." Population-health principles apply across the continuum of health, including primary, secondary, and tertiary prevention, as well as disease treatment and condition management.

Recognizing these principles of population health, the AFMS in the late 1990s launched the Primary Care Optimization (PCO) initiative. PCO involved a massive training and re-engineering effort of all AFMS primary care clinics, to incorporate concepts of population health management, prevention, and early intervention into the practice of routine health care in primary care clinics. Furthermore, PCO provided a context for behavioral health integration into primary care as part of the broader focus on population health.

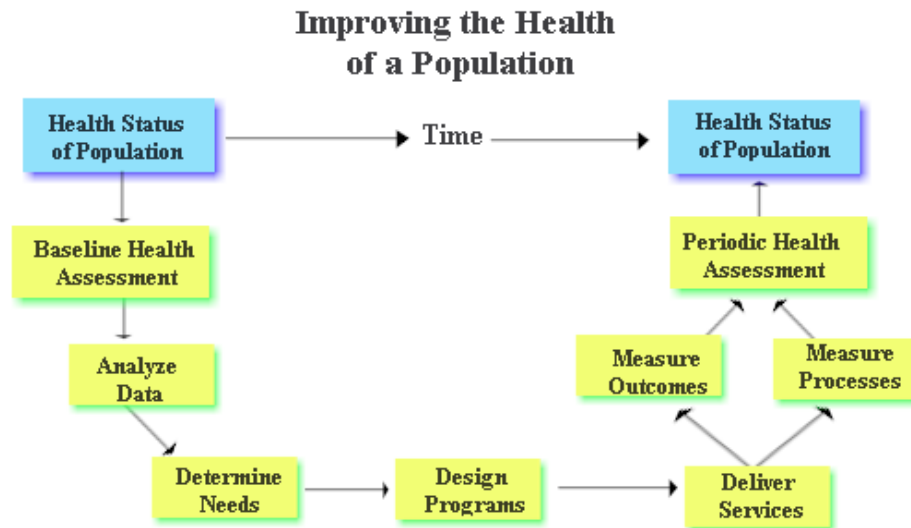
## **APPLYING POPULATION HEALTH TO BEHAVIORAL HEALTH**

The BHOP initiative developed as a small part of the much larger AFMS PCO effort to redesign how we deliver primary care services, broadly conceived. There is now broad consensus that a major component of quality primary health care is identifying and addressing the behavioral health needs of primary care patients.

Extensive writings exist on the application of population health to physical medicine. However, research has articulated its application to the field of mental/behavioral health much less clearly. One such application is the integration of behavioral health providers into primary care clinics—*within a consultative model*. A consultative model implies that the BH provider is a consultant to the primary care team (which has primary responsibility for the patient) and does not function as a specialty mental health provider (see Chapter 2). In other words, simply co-locating specialty mental health providers within primary care clinics is not likely to produce outcomes consistent with population health management (Strosahl, 1997). Specifically, the overall goal of applying population health management to behavioral/mental health issues is to enhance the overall health of the population by improving preventive services, assessment, timely identification of behavioral health needs, and access to BH providers. Fortunately, we can

apply basic principles of population health and key questions from physical medicine to behavioral health.

**Figure 5 illustrates the process of population health management. We can repeat the cycle periodically, reassessing the population's health, recognizing successes in some priority areas, improvement in others, and re-prioritizing new health needs. Figure 5: Population Health Management Model**



This model can be broken into these steps.

## Identify Your Population

The definition of your population will vary. Some examples include all eligible beneficiaries assigned to a base, active duty personnel only, or the enrolled population at an MTF. Whatever the scope of your population, you must define it clearly!

Despite the recent move towards population health, mental health providers have not traditionally been trained in this model and would not consider an entire enrolled population as their customers. Typically, they view their clients as only those who present for care. For illustration purposes only, the reality that a large proportion of AF mental health clinics treat only active duty individuals underscores this philosophy. Although many mental health clinics, in their current model of care, may be overwhelmed with patients, significant, unmet mental health needs continue to exist in the population. Mental health providers must begin to think about an entire panel of enrollees as their population of interest and responsibility. Until this shift occurs, and care is provided beyond the walls of the mental health clinic, unmet behavioral health needs in the AF are not likely to decrease. Therefore, as you define your target population, we encourage you to consider taking a broad, population health perspective.

## **Perform a Health Assessment and Needs Analysis**

Assessing the nature and scope of problems within your population, particularly their risks and needs, is a critical first step. You can accomplish this by using a health-screening instrument with all primary care patients to determine the prevalence of specific problem areas. Such instruments include the Health Evaluation Assessment Review (HEAR), or others specifically designed to screen for behavioral-health risk factors (e.g., the Patient Health Questionnaire; Spitzer, Kroenke, & Williams, 1999).

Another method of performing a needs analysis for a particular clinic involves analyzing data available through the electronic records and billing systems. Each clinic's Health Care Integrator can access information regarding the frequency of various diagnoses coded by primary care providers, as well as statistics on prescriptions and referral patterns. The BHC could use this information to answer questions such as "What are the top two behavioral health problems seen by the PCMs in this clinic?" or "What medical problems associated with behavioral health factors are treated most often by the providers here?" The BHC may use answers to these questions to develop targeted approaches to improve care in these areas.

The Post-Deployment Health Reassessment (PDHRA) may also be useful in performing a health assessment and needs analysis of one segment of a clinic's enrolled population: members who have returned from deployment. Current processes in place already ensure that an individual's responses on the PDHRA result in appropriate referrals for that particular service member. Looking at global (group) results, however, could identify areas warranting additional attention.

## **Target Your Resources to Priority Areas**

Resource targeting may be a function of identifying problems with the highest morbidity in your identified population, those with the highest costs (direct healthcare costs, as well as lost productivity), or problems with the most variability in care. Although priority areas are likely to vary, you should make explicit how you determined them. As part of this process, you will likely have to identify areas of relatively lower importance; otherwise, you will simply be trying to do more. If you do targeting well and thoroughly, it should produce a clearer vision and eliminate less-important activities.

## **Apply Evidence-based Interventions**

The scientific evidence for various behavioral health interventions is rapidly expanding. Well-documented and efficacious treatments are available for many of the most common behavioral health problems (depression, anxiety, relationship problems, and alcohol abuse). Most of the literature describes these interventions as delivered in a specialty behavioral health context, however. For primary care consultation, these specialty behavioral health approaches need to be modified for the unique nature of the primary care setting (e.g., brief and infrequent appointments with an emphasis on consultative interventions and home-based practice; see Chapter 2). There is an expanding literature describing how to adapt evidence-based specialty interventions for specific problems to approaches consistent with a primary care consultative model (e.g., Bryan & Rudd, 2010; Hunter, Goodie, Oordt, & Dobmeyer, 2009; James & Folen,

2005; O'Donohue, Byrd, Cummings, & Henderson, 2005; Oordt & Gatchel, 2003; Robinson, 2005; Robinson & Reiter, 2007).

## **Define Your Performance Measures**

You may relate your metrics to the population of interest, or to the intervention. One example would be reporting on rates of screening/assessment for behavioral health needs in the defined population. Other examples include examining changes in PCM prescription or referral patterns, or changes over time in frequency of behavioral health diagnoses in the beneficiaries enrolled to the clinic.

## **Evaluate and Modify**

Using routine performance measures will make evident which processes are effective and which require modification. You may need to adjust areas of primary importance based on a shift in your population, or by direction from senior advisors. Whatever the reason, a change in focus requires modifying existing performance measures, and possibly developing new ones.

## **ABOUT THIS MANUAL**

This manual introduces the clinician to the roles and responsibilities of a BHC, which describes any mental health provider who 1) operates in a *consultative* role within a primary care treatment team, and 2) offers recommendations and care delivery for behavioral interventions and/or, within appropriate limits, psychotropic medications. This group includes primarily psychologists and social workers. In a much more limited scope, psychiatric nurse practitioners have also begun to function as BHCs.

**NOTE:** In this model, psychiatrists will mainly serve in a consultation/liaison role, which Appendix 3 and Appendix 4 discuss in detail.

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**We encourage providers to read this manual carefully.**

**We have designed it as a practical guide to having a professionally enriching experience as a behavioral health consultant working in primary care. In addition, this is the ONLY model that USAF medical legal consultants have reviewed and support.**

**The AFMS is in the process of developing credentialing standards for BHCs. Once in place, only individuals credentialed to function as a BHC in primary care will provide these services. Until the credentialing standard is in place, only individuals with appropriate training and experience should provide BHC services.**

**We do not intend this manual to substitute for direct clinical training in any way, nor do we consider simply reading it sufficient to begin a BHC service at your facility. Please consider it an instructional resource that must be complemented by clinical training.**

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## **GENERAL DISCLAIMER**

Expert consultants, USAF behavioral health consultants, and multidisciplinary staff at the Mental Health Division of the Air Force Medical Operations Agency have created the content of this manual. Although it does not constitute any official policy of the United States Air Force or Department of Defense, it constitutes the model for delivery of integrated behavioral health care in the US Air Force approved by the Medical Legal division of the Air Force Medical Service. This manual is not intended to create a new standard of care for primary care clinics. It is only intended to describe a program for providing integrated behavioral health services in primary care clinics. Referral to the BHC is based on the PCM's determination that behavioral health interventions delivered in primary care are appropriate and may be beneficial for more fully addressing the patient's health care needs. Please direct all questions, comments, or other feedback on this manual to the BHOP program manager: Maj Robert Vanecek, DSN 969-9295 (210-395-9295), robert.vanecek@us.af.mil. Mailing address:

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# **Chapter 2: Primary Behavioral Health Treatment Philosophy, Program Goals, and Patient Goals**



The concept of “primary mental/behavioral health” describes a new paradigm of behavioral health service delivery in the primary care medical setting (Strosahl, 1994b, Quirk et al, 1995) that is dramatically different from traditional mental health. Table 1 shows the most important conceptual distinctions between primary mental health and specialty mental health. (There are substantial practice-style differences, as well. We address these later in this chapter.)

**Table 1: Conceptual Distinctions of Primary vs. Specialty Behavioral Health Care Models**

Dimension	Primary Behavioral Health Care	Specialty Mental Health Care
1. Model of care	Population-based	Patient-based
2. Primary customers	PCM, then patient*	Patient, then others
3. Primary goals	<ul style="list-style-type: none"> <li>Promote PCM effectiveness</li> <li>Improve behavioral health of population</li> <li>Support small patient-change efforts</li> <li>Prevent morbidity in high-risk patients</li> <li>Achieve medical cost offset</li> </ul>	Resolve patient’s mental health issues
4. Service delivery structure	Part of primary care services	A specialized service, in or out of the primary care clinic
5. Who is “in charge” of patient care	PCM	Therapist
6. Primary modality	Consultation model	Specialty treatment model
7. Team structure	Part of primary care team	Part of specialty mental health team
8. Access standard	Determined by PCM preference	Determined by patient preference
9. Cost per episode of care	Potentially decreased	Highly variable, related to patient condition

\* “PCM” or “Primary Care Manager” refers to credentialed care providers including physicians, physician assistants, and family or women’s health nurse practitioners.

## PRIMARY BEHAVIORAL HEALTH CARE: TREATMENT PHILOSOPHY

Naturalistic studies of PCM/patient interactions reveal that PCMs predominantly use pragmatic advice-giving and behavior change-oriented strategies (Robinson et al, 1995). PCMs tend to use strategies that fit in their 15-minute visits and reliably produce some level of behavior change. Practically speaking, this means the intervention must work in one to three minutes of conversation with the patient. The solution in the primary behavioral health care consultation model is to use an intervention model that fits the realities of daily primary care, and dovetails with existing PCM behaviors to make them more deliberate, consistent, and effective.

The philosophy of primary behavioral health care involves intervening with a wide range of health and mental health complaints. The focus is on resolving problems within the primary care service structure, as well as engaging in health promotion for patients at heightened risk of developing health or behavioral health problems. The primary care culture emphasizes the relationship with the patient over time. This enables the health provider to “carry” at-risk patients and take a “wait and see” approach, without losing contact with them. Patients are encouraged to see their family doctor whenever a physical symptom troubles them, or when they are seeking a professional opinion about a troubling life circumstance. This is why studies of common primary-care complaints show such a low percentage of *bona fide* organic etiology

(Kroenke & Mangelsdorf, 1989). In effective primary care, the PCM is like “one of the family,” whose advice is sought about any number of life’s dilemmas. The patient’s calling card is often a troubling physical symptom, such as headache, stomach pain, or GI distress, indicative of either physical illness or emotional distress.

In general, the goal of the primary behavioral health care consultation service is to position the BHC in the primary care delivery system. BHCs support the PCM, bringing specialized knowledge to bear on problems the PCM thinks require additional support. The BHC may see the patient for a focused assessment and skill building for as long as the primary care provider and the BHC deem necessary in order for good collaborative care to occur. Typically, patients are seen in one to four appointments. Interactions the BHC has with the patient are designed to help the PCM and the patient better target acute and/or chronic problems. Since the BHC is working as a primary care extender and the PCM is the individual responsible for the direction of patient care, BHC appointments ARE NOT the same as specialty mental health appointments that occur in a specialty outpatient mental health clinic, where the mental health provider is responsible for the care of the patient. BHC services are enhanced primary care.

## **PRIMARY BEHAVIORAL HEALTH CARE: KEY PRINCIPLES**

*The BHC’s role is to assist the PCM in identifying, triaging, and managing primary care patients with medical and/or behavioral health problems.*

The most effective clinical model to apply within the consultation framework is the behavioral health approach. The defining characteristics of this philosophy of care are that:

- Maladaptive behaviors are learned and maintained by various external or internal rewards;
- Many maladaptive behaviors result from skill deficits; and
- Direct behavior change is the most powerful form of human learning.

Consequently, consultative interventions focus on helping patients replace maladaptive behaviors with adaptive ones, providing skill training through psychoeducation and patient education strategies, and developing specific behavior-change plans that fit the fast work pace of primary care.

We believe that a behavioral health model can dramatically increase the quality of mental health care provided in the primary care setting for many reasons, through not only improved outcomes in behavioral health, but also physical health.

- The behavioral health model is rich in diagnostic specificity and treatment integration. Many behavioral interventions were developed to treat specific mental disorders, and only then evolved into generalized behavior-change strategies. For example, relaxation training was originally a key strategy in systematic desensitization, but we now employ it in a myriad of behaviorally based intervention packages, in and out of medical settings. Behaviorally based interventions have demonstrated clinical effectiveness with a wide range of mental disorders and psychosocial problems, including depression, panic disorder, generalized anxiety disorder, and chronic pain. Research has demonstrated that you can tailor these approaches to fit in primary care without loss of clinical effectiveness (Katon et al., 1995).

- The behavioral health approach is equally facile at addressing health and illness behaviors (Strosahl, 1994a, Friedman et al., 1995). At this point, behavioral interventions are arguably the most effective strategies for promoting health behaviors (e.g., breast cancer screening, exercise), reducing high-risk behaviors (e.g., smoking cessation), and reducing morbidity and mortality among patients with chronic and/or progressive diseases (e.g., myocardial infarction). See Friedman et al. (1995) for a more detailed review of this literature.
- You can expand the behavioral health approach to fit family or relationship realities just as easily as you can apply it to an individual patient. The BHC can address pertinent family or relationship reinforcers directly in a learning framework. This is important because primary care medicine is not only oriented toward the individual patient, but also emphasizes health and well-being in family living.
- Behavioral health interventions are easily transferable to the patient, using patient-education and self-care models widely employed in the primary care management of chronic diseases such as diabetes. These models focus on teaching the patient self-management and behavior-change skills, and then place more responsibility on the patient for executing them.
- PCMs are pragmatists and naturally gravitate toward behavior-change techniques (Robinson, 1995; Robinson et al, 1995). Therefore, the overlap between “natural” PCM practices and behavioral health strategies makes it more likely PCMs will find them acceptable, and implement them with a much higher degree of fidelity. Properly supported, PCMs can very effectively apply basic behavior-change interventions.

***The BHC program is grounded in a population-based care philosophy that is consistent with the mission and goals of the PC model of care.***

The population-based care perspective provides an enormously flexible and powerful framework for BHC program development. Population-based care is built on a public-health view of service-delivery planning. In this perspective, the service “mission” is not just to address the needs of the “sick” patient, but to think about similar patients in the population who may be at risk, or who are sick but do not seek care. Perhaps more importantly, a population-based care approach provides a specific template for addressing local needs. While the emphasis in designing the BHC role at the AFMS level has been to create a consistent set of core philosophies, it is also important to customize services to address the needs and characteristics of the local population. A few questions involved in typical population-based service planning will illustrate this point: What percentage of the population has conditions like this? How many seek care? Where do they seek care? Do practice/delivery variations result in different clinical outcomes for similar patients? Can we prevent the condition from occurring in patients who have similar risk factors?

You can use the same approach in your BHC service philosophy. For example, what need in behavioral medicine service exists in the population served by a particular PC team? What type of service-delivery structure will allow maximum penetration into the whole population? What types of interventions will work with the “common causes” of psychological distress? What secondary, and more elaborate, interventions are appropriate for a primary care setting? At what level of complexity does specialty mental health better treat a patient? These pivotal questions should directly influence planning for your program.

The following two complementary frameworks address the behavioral health needs of the primary care population through integrated care:

**Horizontal integration** is the platform upon which all BHC services reside because most members of the primary care population can benefit from BHC services delivered in a general service-delivery model. A distinguishing feature of horizontal integration is that it “casts a wide net” for eligibility. From a population-based care perspective, the goal is to enroll as many patients as possible into brief, general, psychosocial services. Traditional primary care medicine is based largely upon the horizontal integration approach. The goal is to “tend the flock” by providing a large volume of general healthcare services, none of which is highly specialized. Providers usually refer patients who truly require specialized expertise to medical specialties. Similarly, we can expose patients with behavioral health needs to non-specialized services, while referring those that truly require specialty care to that system.

**Vertical integration** involves providing targeted, more specialized, behavioral health services to a well-defined, circumscribed group of primary care patients, such as those with major depression. Provision of these services occurs within the primary care setting. This is a major contemporary development in primary care medicine (i.e., a “critical pathway,” “clinical roadmap,” or “best practices” approach). Targets for vertical integration are usually high-frequency and/or high-cost patient populations, such as those with depression, panic disorder, and chemical dependency, and certain groups of high medical utilizers. With respect to frequency, a complaint that patients present frequently in the population (like depression) is a good candidate for a special process of care. With respect to cost, some rare conditions are so expensive that they require a special system of care (for example, patients with chronic behavioral health problems). In behavioral medicine, high utilizers of medical care are, by definition, a small but costly group that is often the target of vertical integration programs. Classroom and group programs might effectively serve numerous patient populations in a typical medical setting, perhaps including group-care programs for those with hypertension, bereavement groups, diabetes education, and so forth.

***Services are based in a primary behavioral health model.***

The primary behavioral health model is consistent with the philosophy, service goals, and healthcare strategies of the PC model of care. It is also capable of addressing the increased service demands that a fully integrated primary care team is likely to encounter. This approach involves providing services to primary care patients in collaboration with team providers. In some cases, it may also involve temporarily co-managing (with the primary care provider) patients who require services that are more concentrated, but which can be managed in primary care. Both types of services are “first-line” interventions for primary care patients who have behavioral health needs. If a patient fails to respond to this level of intervention, or obviously needs specialized treatment, the BHC may recommend that the PCM refer them for more extended specialty care. Consistent with the service philosophy of primary care, the goal of primary behavioral health care is to detect and address the broad spectrum of behavioral health

needs among the primary care cohort, with the aims of early identification, quick resolution, long-term prevention, and “wellness.” Most importantly, your role is to support the ongoing behavioral health interventions of the primary care provider. There is no attempt to take charge of the patient’s care, as is true in specialty mental health. The focus is on resolving problems within the context of primary care service. In this sense, the BHC is a key member of the primary care team, functioning much like the consultative medical specialist. BHC visits are brief (30 minutes), limited in number (often one to four visits, with an average of one to two) and provided in the primary care practice area. Visits are structured so that the patient views your meeting as a routine part of primary care services. The referring PCM is one of your chief “customers” and, at all times, remains the patient’s overall care manager. Table 2 identifies the key practice characteristics that make primary behavioral health care different from specialty mental health care.

**Table 2: Defining Characteristics of the Consultation vs. Specialty Treatment Models**

<b>Dimension</b>	<b>Consultation</b>	<b>Specialty Treatment</b>
Primary Goals	<ul style="list-style-type: none"> <li>• Perform appropriate clinical assessments</li> <li>• Support PCM decision-making</li> <li>• Build on PCM interventions</li> <li>• Teach PCM “core” mental health skills</li> <li>• Educate patient in self-management skills through exposure</li> <li>• Improve PCM/patient working relationship</li> <li>• Monitor, with PCM, “at-risk” patients</li> <li>• Manage chronic patients with PCM in primary provider role</li> <li>• Assist in team building</li> </ul>	<ul style="list-style-type: none"> <li>• Deliver primary treatment to resolve condition</li> <li>• Coordinate with PCM by phone</li> <li>• Teach patient core self-management skills</li> <li>• Manage more serious mental disorders as primary provider</li> </ul>
Session Structure	<ul style="list-style-type: none"> <li>• Limited to one to four visits in typical case</li> <li>• 30-minute visits</li> </ul>	<ul style="list-style-type: none"> <li>• Session number variable, related to patient condition</li> <li>• 50-minute visits</li> </ul>
Intervention Structure	<ul style="list-style-type: none"> <li>• Informal, based on PCM assessment and goals</li> <li>• Lower intensity, longer between appointments</li> <li>• Relationship generally not primary focus</li> <li>• Visits timed around PCM visits</li> <li>• Long-term follow-up rare, typically reserved for chronic or recurrent conditions in a “continuity consultation” approach (see pp. 32 and 59)</li> <li>• When long-term follow-up occurs, frequency is decreased (e.g., quarterly appointments)</li> </ul>	<ul style="list-style-type: none"> <li>• Formal, requires intake assessment, treatment planning</li> <li>• Higher intensity, involving more concentrated care</li> <li>• Relationship built to last over time</li> <li>• Visit structure not related to medical visits</li> <li>• Long-term follow-up encouraged for most patients</li> </ul>
Intervention Methods	<ul style="list-style-type: none"> <li>• Limited face-to-face contact</li> <li>• Patient education is primary model</li> <li>• Consultation is a technical resource to patient</li> <li>• Emphasis on home-based practice to promote change</li> <li>• May involve PCM in visits with patient</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face contact is primary treatment vehicle</li> <li>• Education model ancillary</li> <li>• Home practice linked back to treatment</li> <li>• PCM rarely involved in visits with patient</li> </ul>
Follow-up	<ul style="list-style-type: none"> <li>• PCM remains primary contact for the patient</li> <li>• PCM oversees/reinforces/follows with relapse prevention or maintenance treatment as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Therapist remains person to contact if in need</li> <li>• Therapist provides any relapse prevention or maintenance treatment</li> </ul>

Dimension	Consultation	Specialty Treatment
Referral Structure	<ul style="list-style-type: none"><li>• Patient typically referred by PCM (see Chapter 4 “Self Referral” for further discussion)</li></ul>	<ul style="list-style-type: none"><li>• Patient self-refers or is referred by others</li></ul>
Primary Information Products	<ul style="list-style-type: none"><li>• Brief consultation report to PCM</li><li>• Part of medical record</li></ul>	<ul style="list-style-type: none"><li>• Specialty treatment notes (i.e., intake or progress notes)</li><li>• Part of a separate mental health record with minimal notation to medical record</li></ul>

***Primary care team members are primary customers.***

In all situations, a core service philosophy is that other members of the primary care team are primary “customers.” While you may temporarily co-manage a patient by providing brief behavioral health consultation and intervention, the primary care provider remains in charge of overall care management. Accordingly, the BHC provides services in a collaborative framework. You will tailor your interventions so that other primary care providers can support them in a 15-minute healthcare visit (i.e., interventions that can be reinforced in two to three minutes, maximum). Maintain communications with other PC team members who are involved in the patient’s care. Choreograph follow-up BHC visits to reinforce and build upon existing PC team interventions. The goal is to maximize what is often a very limited number of visits to either the consultant or the healthcare provider.

***The BHC promotes a smooth interface between medicine, psychiatry, and specialty mental health and other behavioral services.***

Promote an *effective* liaison between medicine and a variety of behavioral health services. The underpinning philosophy is that an effective, full continuum of behavioral services is necessary to match a patient’s potential level of need with the level of care. A major system goal is to use effective triage practices to determine which patients you can best manage in primary care, and which require coordinated referral to other behavioral services. This is a bi-directional conduit, meaning that you facilitate referrals into appropriate behavioral services, while being a liaison as cases are transferred back to primary care providers for ongoing management.

## **PROGRAM GOALS**

We designed the BHC’s role in the PC team to accomplish specific individual and system clinical-management objectives. In large part, we derive these program goals from the service philosophy of improving health and behavioral health outcomes for patients with acute, chronic, or recurrent conditions. Table 3 summarizes major program goals.

Table 3: BHC Program Goals and Associated Service Delivery Features

BHC Program Goals	Service Delivery Features
1. Improve clinical outcomes for acute conditions through assessment, intervention, follow-up monitoring, and/or appropriate triage	1. Use short-term, collaborative-care intervention model; implement best-practice guidelines for high-frequency conditions such as depression; build on existing PC interventions/suggest new ones; coordinate acute-care management with primary care team
2. Use prevention and wellness strategies to prevent the onset of a mental disorder or prevent its recurrence	2. Open-door service philosophy encourages broad-spectrum referral pattern; use PC team structure to monitor “at-risk” situations such as life stresses/transitions
3. Provide consultation and education for PC team in use of appropriate psychosocial treatments and, within appropriate limitations, medications	3. Employ collaborative treatment model emphasizing co-management of patient care; offer basic consultation visits to address care-management issues; develop/model interventions that are tailored to the “15-minute hour”
4. Manage high-utilizing patients with chronic health and behavioral health concerns to reduce inappropriate medical utilization and to promote better functional outcomes	4. Longer-term BHC case management follow-up reserved for the small number of patients with numerous medical and or psychosocial concerns; permits less-intensive management of cases over time; employ brief intervention or psychoeducation classes to promote better self-management
5. Manage behavioral and emotional aspects of acute or chronic medical conditions	5. Use patient education in individual and group formats to promote treatment compliance, lifestyle change, and adjustment to physical symptoms/limitations; work with PC team members to identify and manage psychiatric symptoms arising from physical disease
6. Accurately identify and place patients who require specialized mental health treatment	6. Develop and employ referral criteria to triage patients to specialty care; function as a liaison between specialty system and PC team
7. Make BHC services accessible to all eligible beneficiaries within the PC team	7. Service is provided in population-based care framework using both horizontal and vertical service-delivery methods; provide limited number of brief visits using both scheduled time and on-demand appointments; develop effective classroom and group programs in collaboration with the health education specialist (if available); BHC acts as part of PC team to raise awareness about behavioral health issues; BHC functions in primary care practice area to promote easy referral of patients
8. Expand behavioral health impact beyond traditional office based appointments	8. Examples include use of telephone, email, population health screening, webcasting, as appropriate per local MTF guidance and capability

## PATIENT/CLINICAL OUTCOME GOALS

### Patient Goals

We designed the services provided in the primary care general consultation program to achieve three main patient goals:

1. Enhance the short-term clinical outcomes of the PCM’s health or mental health interventions for patients with mental health or medical concerns
2. Enhance longer-term outcomes in patients with recurrent, chronic, or progressive medical or mental health conditions

3. Decrease medical utilization and costs by providing appropriate behavioral health support to patients who need ongoing social support, or who have chronic and treatment-resistant mental and/or medical problems

### ***Enhance Short-term Outcomes***

Short-term outcomes involve those associated with an “acute” episode of care provided by the primary healthcare provider. In general, this involves helping healthcare providers recognize and treat mental disorders and psychosocial stress at the point of initial presentation. The key goal is to help the healthcare provider intervene early, and appropriately, to address the patient’s concerns.

The behavioral health specialist has much to offer in this area, for it requires expertise in screening, differential diagnosis, and clinical competence in applying empirically supported interventions for particular conditions, as well as the ability to tailor those treatments for the fast pace of primary care visits (cf., Robinson, 1995). There is a definite medical cost associated with a failure to properly diagnose and treat acute mental health conditions. For example, nine specialists will have seen the average patient with panic disorder in medical settings before making a definitive mental health diagnosis. Other research suggests that depressed patients utilize about four times as much medical services yearly as their age- and sex-matched, non-depressed peers (cf., Strosahl, 1994a).

There are many potential ways to influence the course of treatment provided by primary healthcare providers using an integrated behavioral health model. For example, recent research has suggested that this model leads to superior outcomes for depressed primary care patients in a wide range of areas (e.g., use of coping strategies, compliance with medication, use of relapse-prevention strategies). On the PCM side, superior outcomes involve a greater likelihood of using an appropriate dose of anti-depressant medication, discussing behavioral and relapse-prevention strategies with patients, and, most importantly, preferring an integrated model over a referral to specialty mental health care (Katon et al., 1996; Robinson, Wischman, & Del Vento, 1996).

Remember, while depression is currently a popular research target in primary care, patients present a myriad of acute concerns to their nurse, medical assistant, or PCM, ranging from somatic complaints to problems with a spouse, child, or work supervisor. In each circumstance, patients expect their healthcare provider to offer some intervention. The main impact of behavioral health consultation with these common psychosocial stresses is to resolve them before they lead to more significant mental health problems. Preventing mental health morbidity through these types of interventions is a wise, long-term investment.

### ***Enhance Long-term Clinical Outcomes***

It is perhaps in the area of long-term health outcomes that the most robust literature supports a primary care general consultation model. For conditions such as heart disease, cancer, diabetes, and arthritis, management outside the acute, specialty phase of treatment often falls to the primary healthcare provider. Often, the most salient interactions about lifestyle and stress-management issues occur after surgery or other invasive treatment, when the patient is stabilized. Heart disease is an excellent example. Numerous studies have shown that depression, anger, and a socially isolated lifestyle are associated with decreased survival time following heart surgery (cf., Frasure-Smith, 1991). You may play an important role in working with both the PCM and patient on factors that promote long-term behavior change. Since decreased survival time is



associated with repeated hospital admissions and expensive secondary surgeries, effective consultative intervention is not only an enormous cost savings, but also a huge increase in the patient's quality of life.

We know that many mental health conditions recur without appropriate relapse-prevention efforts. For example, depressed patients treated solely with an anti-depressant medication are very likely to relapse when they stop taking it. It makes no sense for a PCM to initiate anti-depressant therapy without also exposing the patient to behavioral strategies for managing depression and preventing relapse. An appropriate behavioral intervention can have a major impact in stopping the revolving door for depressed patients in primary care.

Behavioral health technology may also make a major impact in relapse prevention, as well as the prevention of long-term problems that arise from well-intentioned, but iatrogenic, short-term care. An excellent example is the patient experiencing intense anxieties related to family, marital, or career issues whom a provider starts on an open-ended regime of benzodiazepines. Another example is the back-injury patient whom a provider places on temporary work disability, then starts on pain medications, with the instruction to take them until the pain goes away. In fact, primary care is full of encounters that could involve short-term treatment fueling long-term problems. Behavioral health interventions have a major role to play in deterring the iatrogenic and reinforcing effects of the short-term relief strategies that PCMs often feel compelled to use. By changing the message and expectations associated with these strategies, we may prevent many chronic conditions. For example, we may give the situationally anxious patient brief instruction in relaxation strategies, and then encourage them to use an audio taped relaxation program at home daily, before or after stressful situations. We might ask a back-injury patient to keep a daily physical-activity log, to prevent an over-reliance on bed rest that, paradoxically, may worsen back pain. By changing the content of care and our expectations of the patient, we may prevent many chronic conditions.

### ***Support Patients with Chronic Conditions***

Primary care has a population of patients who chronically use medical services at high rates, due to a medical condition, a mental disorder, psychosocial concerns, or a combination of these. While the cost of this chronic population is not clear, it is clear that this group is frustrating to healthcare providers. In some cases, patients may make these visits for social support. In other cases, the patient is seeking a "miracle" cure for a chronic condition, such as low-back pain. On other occasions, psychological factors are clearly implicated in physical dysfunction, but the patient is not receptive to anything other than more medical tests and treatments.

The common element of this patient group is that they use expensive health services without much of a positive, demonstrable health or mental health outcome. We do not mean to diminish the patient's pain, suffering, or sense of need, but suggest that the PCM may not be able to consistently address these issues constructively. Behavioral interventions may have a major impact on this group by shifting reinforcements, so that visiting a BHC is more attractive, less expensive, and with less chance of expensive, unneeded, and potentially risky specialty medical tests and services. Over time, this may reduce a patient's resistance to examining and working on behavioral factors that contribute to their chronic suffering.

Taken as a whole, we designed the primary behavioral health care model to meet the following goals.

## **Clinical Goals**

- Assist primary care health providers in recognizing and treating mental disorders and psychosocial problems
- Assist in the early detection of “at-risk” patients, with the aim of preventing further psychological or physical deterioration
- Assist the healthcare provider in preventing relapse or morbidity in conditions that tend to recur
- Assist in preventing and managing addiction to pain medicine or tranquilizers
- Assist in preventing and managing work and/or other functional limitations
- Help healthcare providers obtain positive clinical outcomes with high-prevalence mental disorders
- Help PCMs efficiently and effectively treat and manage patients with chronic emotional and/or health problems
- Help PCMs manage patients who use medical visits to obtain needed social support
- Over time, improve the quality of PCM interventions without the aid of consultation
- More efficiently move patients into appropriate specialty mental health care, when indicated, and to subsequently ease their transition back to primary care management

## **Service Quality Goals**

- Increase PCM/healthcare provider satisfaction with access to, and quality of, mental health services they utilize for their patients
- Address consumer preferences on receiving routine behavioral health care in primary care
- Increase overall consumer satisfaction with mental health services along selected dimensions (initial access, access to follow-up care, coordination of care, etc.)
- Increase job satisfaction of mental health providers

## **Cost Goals**

- Provide necessary clinical services cost-effectively
- Reduce the overall cost of providing specialty mental health care to patients, in particular to those with less-pervasive mental health needs
- Reduce the overall medical costs associated with mental disorders, psychosocial issues, medical disabilities, or chronic or progressive disease states
- Decrease costs for private-sector mental health care; particularly, recapture care for mental health problems that can be effectively and efficiently treated in the direct-care system

# **Chapter 3: Primary Behavioral Health Services and Consultant Roles**

## CATEGORIES OF PRIMARY BEHAVIORAL HEALTH SERVICES

Primary behavioral health services include a package of two basic “approaches.” You must deliver them consistently.

- Primary care general consultation services (horizontal integration)
  - Brief general consultation (typically 1 to 4 visits)
  - Psychoeducational class consultation
  - Continuity consultation (sometimes referred to as specialty or case management consultation; 4+ visits)
- Population-based integrated care services (vertical integration)
  - Clinical practice guidelines / “best practices” recommendations
  - Special coordinated services
  - Disability prevention/management services

### Primary Care General Consultation Services

You deliver primary care general consultation services in the primary care clinic, and they are available for any patient referred by a healthcare provider for any behavioral health reason. You are a member of the primary care team. Overall, the primary objectives are to:

- Assist the healthcare provider in recognizing, treating, and managing mental disorders and psychosocial issues, including work-related issues such as disability prevention and management;
- Enhance the skills of the primary care team in regard to management of mental health issues;
- Provide specific, focused interventions for primary care; and
- Provide follow-up and relapse-prevention plans.

Consultation may involve recommending appropriate behavioral intervention strategies and/or pharmacotherapy (within the BHC’s scope of practice), and it is tailored to fit the fast pace of primary care.

There are three basic types of general consultation services: **brief**, **psychoeducational**, and **continuity** ([see Chapter 5 for more information on service types](#)). Brief consultation is time-limited and usually appropriate for primary care patients who have moderate to high levels of functioning. Psychoeducational class visits provide a group or classroom approach for intervening with high-frequency primary care populations, such as depression, anxiety, or chronic diseases. Continuity consultations serve primary care patients who require more assistance, but who nevertheless are best treated in primary care, versus specialty services in a mental health clinic. Continuity consultation is appropriate for patients with chronic medical and/or psychological conditions who require a continual, intermittent, consultative approach. Such patients might be seen less frequently over longer periods of time (once per quarter for several years) than patients seen in a brief consultation model (1 to 4 appointments over several months).

We discuss “core” consultation services typically requested and provided in the primary care general consultation model in the sections that follow. Many clinical services can be provided under the rubric of “behavioral health consultation” or “consultation/liaison psychiatry.” In

general, these services involve directly assisting the PCM in treatment planning and monitoring, addressing patients' community-resource needs (including specialty mental health referrals), and follow-up consultation as part of a chronic- or acute-care treatment plan, as well services for the staff itself to address team-building or personnel issues.

## **Population-based Integrated Care Services**

We designed these services (sometimes called condition management) to integrate the treatment activities of the PCM and behavioral health consultant with:

- Populations with *high-prevalence, high-impact* (in terms of medical outcomes, resource use) mental disorders, such as depression or panic disorder (clinical practice guidelines or “best practices” recommendations)
- *Low-prevalence, high-impact* populations of heavy utilizers of medical and/or mental health services who do not obtain obvious clinical benefits (special coordinated services)
- Populations at risk for developing *long-term physical or mental disabilities*, such as patients referred for medical care after an on-the-job injury, or who have been placed on a temporary work disability due to a physical or emotional problem (disability prevention/management services)

### ***Clinical Practice Guidelines / “Best Practices” Recommendations***

These programs present a consistent, intervention-package approach to an identified patient population, usually those with a high prevalence in the primary care population. Examples include those with uncomplicated major depression, dysthymic disorder, and sub-threshold depressive symptoms. Other potential pathway programs might involve patients with panic disorder or somatization. For the initial training, we selected uncomplicated depression as the standard clinical practice guideline to teach and implement.

### ***Special Coordinated Services***

These services integrate the activities of the PCM and behavioral health specialist with lower-volume, high-cost patients treated primarily in the medical setting. An example is effective case management and treatment services to primary care patients who are high utilizers of health (and often mental health) care as a function of chronic psychological/medical conditions.

This does NOT imply that you should do case management (i.e., complete forms for secondary insurance or other services, etc.), nor should you perform medical social work tasks. Many primary care clinics already have a team member for utilization management (UM; likely the health care integrator), so there is no need for the BHC to duplicate services. However, you may be a useful resource for the UM leader.

## **Other Parameters of Primary Behavioral Health Care: Population, Customers, and Excluded Services**

### ***Population***

In general, the target population for this service is any eligible beneficiary of a particular MTF, which may include individuals, couples, or families. Most BHCs will primarily provide consultation services for adult patients. If you have specialty training to assess and treat children, you may consider children within the scope of your target population. If you do not have specialty child training, you may conduct an initial consultation appointment to assist the PCM with recommendations for referral outside the clinic. The goal of the general consultation service is to provide services, in a population-based care model, to any patient who needs them, regardless of the nature, intensity, or severity of their concerns. This includes any PCM-referred patient, any self-referred patient, and those not referred to the BHC but who are suspected of having behavioral health needs. In general, PCMs and other healthcare providers are encouraged to refer any patient whom they believe may benefit from a general behavioral health consultation for any behavioral health issue. This population-based approach means that patients experiencing the stresses of daily living (family conflicts, job stress, or life-planning issues), those with mental disorders, and those with chronic medical/mental conditions are all appropriate referrals. However, if the assessment or intervention for a particular patient is outside your scope of practice as a BHC, you would make an appropriate referral.

### ***Customers***

You have four primary customers for these clinical approaches:

1. The PCM and/or healthcare provider
2. The patient who is referred for services
3. The family members of patients who may be affected by the index condition
4. The USAF, especially in the case of work disability or job-performance problems

The healthcare providers are your primary customer, in that they are solely responsible for decisions regarding the content and form of treatment.

### ***Excluded Services***

- Medical social work services (other than routine, community-resource referrals)
- Specialized case-management services
- Psychotherapy or diagnostic procedures exceeding brief assessment or brief intervention or your scope of care (see also [\*Indications for Alternative Placement\*](#))
- Long-term, group psychotherapy services (although psychoeducational classes offered in primary care are appropriate)
- Specialized occupational health, special duty evaluations and/or disability-management services
- Command-directed evaluations (CDE)
- Forensic evaluations, sanity boards and Medical Evaluation Boards

Existing behavioral services in the MTF may better provide these services. When you receive a request from a patient or a primary care team member for any excluded service, you can

facilitate placement in the appropriate behavioral services program. **NOTE:** It is within your purview to provide brief intervention and/or triage services to PC team members who are experiencing symptoms of emotional distress. However, you are encouraged to use appropriate clinical judgment, as well as caution, so you don't become overly involved in departmental conflicts that may undermine your role in the clinic.

## CONSULTANT ROLES

### The Behavioral Health Consultant

The behavioral health consultant is typically a privileged social worker or psychologist<sup>1</sup> (see BHC Job Description in Appendix 4). The consultant provides support and assistance to both PCMs and their patients, without engaging in any form of extended specialty mental health care. BHC responsibilities include triage and consultation at a PCM's request. BHCs will also be available for behavioral consultation, pain management, and difficult diagnostic, occupational health, and complicated-treatment issues.

We have specifically designed the behavioral health consultant approach to avoid the "black hole" of specialty mental health care, in which a patient is referred to mental health, but there is no communication among providers. To avoid this type of patient care, you should know how the consultation and specialty therapy approaches differ in their service goals and practice styles.

In general, the consultant does not provide extended, intensive mental health treatment to a patient. Some consultations are single-appointment visits. The BHC may recommend a behavioral intervention to the patient, and provide immediate feedback about psychological intervention strategies to the referring provider. Interventions are simple, "bite-sized," and compatible with those that the PCM can provide in a 15-minute healthcare visit (i.e., interventions that the PCM can suggest or reinforce in two to three minutes, maximum). It is also clear to the patient that you are helping both the PCM and patient come up with an effective and comprehensive healthcare plan. The consultant choreographs follow-up consultations between the BHC and the patient to reinforce PCM-generated interventions. The goal is to maximize what often is a very limited number of visits to either the consultant or the PCM. Thus, you can follow patients needing longer-term surveillance in a manner that is very consistent with the way PCMs manage their at-risk patients.

The PCM, who is still responsible for choosing and monitoring the results of interventions, always coordinates care. The primary care provider "owns" these cases. Communicating back to primary care providers is one of your highest priorities, even if it means handwritten notes or staying late for a face-to-face conversation. You will communicate with PC providers verbally (face to face, or over the telephone) and in writing.

A final notable aspect of the consultant model is that it allows for *in vivo* training of the PCM, built around specific casework. With feedback regarding hundreds of patients sent to you, PCMs begin to see the same themes recur in their patient panel and gain first-hand experience

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<sup>1</sup> Any BHC is expected to be a privileged provider, but is not required to be privileged to practice independently (i.e., can be supervised). Psychologists and social workers can be privileged providers. The AFMS recognizes nurse practitioners (NPs) as privileged providers and they may function as BHCs if they have the appropriate BHOP training.

using effective strategies, supported by the behavioral health consultant. Eventually, the PCM integrates the skills, and begins to implement both psychological and pharmacological interventions more effectively.

## Typical BHC Services in Primary Care

Behavioral health consultation services can be grouped into a number of broad categories, based on goals and format of the consultative service provided:

- *Behavioral health initial consultation:* Initial visit with a patient referred for a general evaluation; focus is on diagnostic and functional evaluation, treatment recommendations, and forming behavior-change goals; may include identifying whether a patient could benefit from existing community resources [e.g., - Military OneSource, medical social work, or the Integrated Delivery Systems (IDS)] , or suggesting to the patient and the PCM that a referral to specialty mental health may best serve the patient's needs
- *Behavioral health follow-up consultation:* Secondary visit that supports a behavior-change plan or intervention based on earlier consultation; often occurs in tandem with a planned PCM visit
- *On-demand behavioral health consultation:* Usually unscheduled, PCM-initiated contact, either by phone or face-to-face; generally an emergent situation requiring immediate or short-term response
- *Telephone consultation:* Scheduled intervention contact or follow-up with patients conducted by telephone, rather than in person
- *Psychoeducational class:* Brief, group-based intervention that replaces or supplements individual consultative intervention; promotes education and building skills. Often, a psychoeducational class can and should be the primary psychological intervention, as you can best address many behavioral health needs in this setting
- *Conjoint consultation:* Visit with PCM and patient to address an issue of concern to both; often involves addressing a conflict between them
- *Care management:* Designed to minimize extensive and uncoordinated delivery of medical and/or mental health services, usually for chronic psychological and medical problems; involves linking patient to a care-management plan that includes multi-disciplinary involvement
- *Team building:* Conference with one or more members of the healthcare team to address peer relationships, job stress, or process-of-care concerns
- *PCM consultation:* Face-to-face visit with PCM to discuss patient care; often involves "curbside" consultation
- *Continuity or specialty consultation:* Continuity consultative services assist patients requiring ongoing monitoring and follow-up. It is applicable to those with chronic stressors, marginal lifestyle adaptation, chronic medical conditions, etc.

Additionally, these broad categories of behavioral health consultation services may have a specific focus (e.g., compliance, relapse prevention, etc.) as described below. Focus on these areas may occur within a variety of the formats discussed above (e.g., behavioral health initial or follow-up consultation, telephone consultation, psychoeducational class, conjoint consultation, etc.).



- *Compliance enhancement:* These services help patients comply with interventions initiated by PCM. There is often a focus on education, addressing negative beliefs, or increasing strategies for coping with medication side effects. (**NOTE:** Compliance enhancement visits are highly effective in helping PCMs improve their treatment for depression in the primary care clinic. For example, the BHC may set up a process to routinely see patients who are prescribed anti-depressant medications, to address common myths and misunderstandings [see Appendix 5], and schedule a follow-up appointment to assess compliance and medication response.)
- *Relapse prevention:* These visits maintain stable functioning in a patient who has responded to previous treatment. Relapse prevention visits may be planned and spaced at long intervals (e.g., every 2 to 6 months) or may be triggered by conditions on the patient's relapse prevention plan (e.g., a 5 pound weight gain in an individual who had been maintaining a weight loss following behavioral health consultation).
- *Behavioral medicine:* These visits assist patients in managing chronic medical conditions, or tolerating invasive or uncomfortable medical procedures. The focus may be on lifestyle or health-risk factors (i.e., smoking, overweight or obesity) among patients at risk for development of health problems. Visits may also involve managing issues related to progressive illness, such as end-stage chronic obstructive pulmonary disease, cancer, etc.

### **The Consultation/Liaison Psychiatrist\* (CLP)**

Psychiatry may fill numerous and varied roles in collaboration with primary care. This section describes only the role of psychiatrists in the BHC model.

By policy, the Air Force does not support psychiatrists functioning as BHCs. In the BHC model, the recommended role of psychiatry is primarily that of a consultant to the BHC or PCM on more difficult cases, specifically on pharmacotherapy. The BHOP working groups and the psychiatry consultant to the AF Surgeon General discussed this role at length. Although their scope of practice will not be formally limited, psychiatrists will be discouraged from assuming the role of a BHC, primarily because they are more costly and can perform functions that other BHCs cannot (e.g., consultations and prescriptions for specific medications, dosages, etc.). This will allow psychiatrists to follow the PCO plan of having all individuals involved with patient care work at the peak of their scope of practice. Due to limited manning, the availability of psychiatrists is likely to vary considerably, and BHOP does not recommend an algorithm for psychiatry staffing.

As part of BHOP, the consultation/liaison psychiatrist's (CLP) primary responsibility is to enhance the PCM's management of psychoactive medications by providing informal verbal consultation on initial medication decisions, changing medications, and managing side effects. The CLP will also advise the PCM regarding work-ups of neuro-psychiatric symptoms (e.g., need for neuro-imaging, lab testing, EEG, etc.) and ongoing management of psychotropic medications (e.g., drug-level monitoring, chemistry/CBC/urine testing, etc.). Upon request, they will also consult with BHCs regarding medication requests, and cases involving diagnoses and treatment that are more complicated. You can expect to seek additional consultation from the CLP in roughly 10 to 15 percent of cases (or one in eight patients). After initial consultation, the BHC may recommend that the PCM send partial medication responders, non-responders, or

medically complicated cases directly to the CLP, with eventual return of care management to the PCM. The CLP's level of involvement with individual patients may vary from minimal to extensive.

\* The term Consultation/Liaison Psychiatrist as used in this manual does not refer to specialty fellowship training in Psychosomatics. In this manual, CLP refers to a role that a Psychiatry residency trained physician could fulfill in interactions with primary care physicians.

***See Appendix 3 and Appendix 4 for a more  
thorough discussion of the CLP role.***

# **Chapter 4: Service Procedures**

## WAYS TO ACCESS BHC SERVICES

### PCM Request for Consultation (Written or Verbal)

A written or verbal request from the PCM will be the most common way a patient accesses BHC services. PCMs should be asked to provide a written consultation request through the AHLTA system for each referral. You will see the patient for a behavioral health initial consultation visit as soon as possible. Following the first appointment, you will collaborate with the PCM to decide whether the patient fits the profile for primary care, or should be referred to specialty mental health. If the patient is already receiving care in specialty mental health, you will see the patient or consult with the primary care provider, as requested, then act as a liaison back to the specialty mental health provider. ***Regardless of who is present at the consultation visit, the consultative process always involves providing written and/or verbal feedback to the referring provider.*** Often, the BHC and healthcare provider will find it useful to discuss questions and projected outcomes before the first consultation visit with the patient. When this is possible, it is more likely to generate outcomes consistent with the healthcare provider's goals. **NOTE:** Ideally, the PCM or other PC staff member will schedule a patient directly for this consultation before the patient leaves the clinic, so that the patient has a date and time in hand. However, depending on individual PC clinic procedures, the patient may be asked to schedule the appointment.

### BHC Recapture of Specialty Mental Health Referrals

We encourage you to form a partnership with the specialty mental health clinic so that, as their technician or administrative staff receives referrals from PCMs or other providers, they will contact the referring provider and ask if BHC services might be acceptable as part of a stepped-care approach, if they believe they may be more effective. Ultimately, the goal is to also involve the TRICARE Service Center in this role, so they are aware of your services before they outsource care. This same process could eventually apply to self-referrals to mental health clinics.

**NOTE:** TRICARE coverage currently provides beneficiaries with up to eight mental health sessions from a network provider before any authorization is required. Thus, even when such patients may be appropriate for BHC intervention, it will be difficult to recapture this care. You can only ensure that you effectively market your service to increase awareness among all beneficiaries, and have a process in place to ensure that you first see or screen any referral to specialty mental health at the MTF.

**Decision factors:** Patient preference regarding service location, nature of the presenting problem (see Chapter 3 for discussion of excluded services and Chapter 4 for discussion of patients in crisis), specific provider attributes, and specialized programs of care.

**Remember:** The goal is to have the BHC in primary care see all referrals to specialty mental health *first*!

### Self-Referral

As you establish your service in the primary care clinic, patients likely will begin to refer themselves, without a specific referral question from their PCM. In such cases it is critical that

you identify the patient's PCM, ***inform the patient that you will provide feedback on the visit to their PCM and then provide feedback to the PCM to ensure they agree with and support your work with the patient.*** You determine the depth of verbal feedback provided to the PCM on a self-referral; however, the same documentation guidelines apply. You should remember the service philosophy and program goals with self-referrals: the PCM remains in charge of the patient's care, and should be adequately informed and involved with all aspects of care. **NOTE:** Once you have established this service in the primary care clinic, PCMs will also refer patients directly into psychoeducational classes you offer. Ordinarily, PCMs will be encouraged to state in writing their referral question or rationale for your involvement. This should help synchronize provider and consultant goals. However, you will see patients who do not have a formal, written referral or question, with the understanding that you will link back to the PCM following your initial consultation.

## FUTURE DIRECTIONS FOR BHC SERVICES

There exist many opportunities for future growth of BHC services. We particularly encourage the use of routine screening methods, development of clinical pathways in a "vertical integration" approach, use of outcome measures, and increased marketing of BHC services.

We encourage you to consider using existing, routine screenings to identify individuals who may benefit from brief behavioral health interventions. For example, all active duty members receive annual Preventive Health Assessments, which include completion of the Health Evaluation Assessment Review (HEAR) or a similar instrument. The HEAR is a comprehensive tool designed to identify needed screening or intervention. It includes several questions pertaining to mental health and, therefore, can identify individuals who report behavioral health symptoms. You can then talk with these patients at least briefly, to determine if they need or desire additional intervention. Other instruments can accomplish a similar goal. As discussed previously, the PDHRA identifies individuals who are reporting behavioral health symptoms after return from a deployment. The BHC may recommend implementing local procedures to carry out PDHRA policy that include a phone or in-person BHC appointment for service members screening positive. **All such contacts must be reported back to the PCM per the consultation model.** Other useful screening instruments include the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001), Patient Health Questionnaire-2 (PHQ-2; Kroenke, Spitzer, & Williams, 2003), or Duke Health Profile (DUKE; Parkerson, Broadhead, & Tse, 1990) to effectively identify those seeking medical care who may also have behavioral health needs and could benefit from intervention (see Appendix 6). See section "Assessment Instruments" in Chapter 4 for additional information.

To date, most AFMS BHC services provide primarily general consultation ("horizontal integration") services. Few have developed clinical pathways for specific, high cost/high impact problems in a population-based ("vertical integration") approach (see Chapter 2). We encourage BHCs to identify (using a needs assessment, if needed) conditions that might benefit from a more coordinated, structured "condition management" approach. Examples might include depression, over-utilization of medical services, or panic disorder.

To assess the impact of BHC services, we recommend that BHCs conduct program evaluation. These could include patient satisfaction surveys, provider (PCM) satisfaction

surveys, or monitoring of medical or behavioral health outcomes with standardized measures. Chapter 5 contains additional information about conducting a program evaluation.

Finally, we recommend increased advertising of BHC services to increase use of the BHC. You can consider advertising your services through the Integrated Delivery System at your base. Base IDS representatives compile a list of helping agencies for particular problems; they may ultimately list the BHC for increased awareness. Other marketing strategies include locating BHC brochures and posters in the primary care clinic waiting area or other areas of the medical facility. You might also consider working with the PC clinic's Health Care Integrator to discover ways in which BHC marketing might be included with other routine health messages that are routinely disseminated to clinic enrollees (e.g., through quarterly mailings, etc.).

## INDICATIONS FOR ALTERNATIVE PLACEMENT (SPECIALTY MENTAL HEALTH)

In general, you should not exclude any patient from an initial consultative visit based on *a priori* factors. The goal of your initial consultation is a triage analysis of the likelihood that the patient would benefit from primary behavioral health care. You should refer patients who clearly have serious mental disorders into specialty care after this visit. You accomplish this by making an explicit recommendation to the PCM that he or she should refer this patient to specialty care. With the exception of these severe and obvious cases (which are generally infrequent), ***a primary indication for alternative placement is the patient's failure to respond to a reasonable regime of behavioral health consultation or consultation/liaison psychiatry, undertaken in collaboration with the healthcare provider.*** The primary care provider, with your consultation and recommendation, will decide whether to refer a patient to specialty mental health for more intensive care. For example, a substantial change in treatment objectives or the patient's needs may warrant a referral to specialty mental health. Communicate with the primary care provider in a timely manner when recommending a referral to specialty mental health. Although the BHC can facilitate the referral, it is the PCM's responsibility to formally initiate it and follow through.

Regardless of your assessment and recommendation for level of care, you must always consider patient preference when determining whether to refer to specialty mental health treatment. If a patient ever requests to see specialty mental health, you should honor this preference, even if the PCM suspects they would benefit equally from the BHC.

Also, be aware of the case in which you determine that specialty mental health treatment is indicated, but the patient refuses to see a specialty mental health provider. Although you may see these patients, the focus and level of services provided must still be commensurate with your role in primary care, and *should not* extend beyond that scope of care. In such instances, you can continue to follow this patient only if you *explicitly* inform him or her of your recommendation, and document that they declined the recommended intensity of treatment (i.e., specialty mental health). You should also communicate this information to the PCM, and ensure the PCM is aware that ***they*** are responsible for either securing appropriate treatment for this patient's psychiatric condition, or managing it themselves. It should be evident to all providers and the patient that the PCM is responsible for managing this patient's psychiatric condition. We also recommend that you and the PCM continue to recommend specialty mental health services, as long as such services are indicated.

## **PATIENTS PRESENTING WITH SUICIDAL IDEATION**

This section is intended to provide guidance for the management of patients who present to primary care with suicidal ideation. Guidance included in this section is consistent with the Air Force Guide for Managing Suicidal Behavior: Strategies, Resources and Tools (2002), which is the recommended guide for assessing and managing suicidal patients in specialty mental health (SMH) care. However, the recommendations below have been adapted to be more consistent with the culture of primary care and the scope of practice for BHCs. Although this section focuses on patients with suicidal ideation, the general approach is also appropriate for use with those experiencing homicidal ideation. NOTE: Guidance offered in this section is not intended to be proscriptive or required. Local primary care clinics may consider it a model that can be adapted to local circumstances.

In any field that is relatively new, and therefore lacking an established standard of care, there are different opinions regarding the scope of care and appropriate procedures within that scope. Such is the case for primary behavioral health care on the issue of suicidal patients. Secondary to enthusiasm for BHOP, many BHCs, and even their local leadership, are eager to make services as robust as possible, especially in locations where referral resources are limited. Appropriately, they seek to have BHOP services render definitive care for most persons referred without excessive referral to SMH and to provide high-quality, one-stop-shopping to beneficiaries. These goals are appropriate and consistent with the Air Force's vision for BHOP. However, caution is warranted to ensure that local BHCs do not extend themselves beyond the practice model approved by the Air Force, especially in management of patients with suicidal ideation. Considering the lack of well developed standard of care within the field of primary behavioral health care on this issue, the rationale for the model suggested below is based upon two justifications. First, the Air Force has a robust system of mental health services available, including specialty mental health clinics. Imminently suicidal patients are clearly outside the scope of BHOP. Specialty mental health clinics are better equipped to provide the thorough assessment and ongoing care necessary to provide the highest quality services to these patients and are the most appropriate level of care for them. Second, this approach is designed to protect providers from going outside the boundaries of the BHC role as defined by the Air Force by offering more concrete recommendations than have been available in the past.

Air Force BHCs practice within a robust medical system in which specialty mental health services are readily accessible. In that context, it is important to remember BHOP's position within the continuum of care that includes self care, non-medical community resources, traditional primary care treatment, BHOP, traditional outpatient mental health, partial hospitalization and inpatient care. BHCs work to ensure that patients receive the right care, at the right time. Consistent with a stepped care model, in most cases where the patient's needs are beyond the scope of BHOP, BHCs should work with PCMs to refer patients who require a higher level of care, either for more extensive assessment or extensive safety planning and treatment, to SMH as the next step in the continuum of care. This does not preclude BHCs from working with PCMs to arrange for direct transfer to inpatient care in appropriate situations. However, this should be a relatively rare occurrence given that outpatient management through SMH is typically the most appropriate and most effective course of action in a majority of cases (Rudd et al., 1996).

The population health foundations of BHOP include the idea that allocation of intensive resources to a single patient comes at the expense of reduced resources for other patients. Thus the BHC's goal of having the broadest possible impact on the health of the beneficiary population is best served by avoiding, when possible and appropriate, intensive and time consuming interventions that are more characteristic of specialty care. From this perspective, it is important that each component of the Air Force continuum of behavioral health care function optimally by fulfilling the roles for which it is best suited. Although there are certainly areas of overlap, each component of the system is designed to provide particular services under certain circumstances. While this guidance will attempt to distinguish the roles of BHOP and SMH with regard to suicidal patients, it is important that any suicidal patient within a particular MTF should receive appropriate care with regard to risk assessment and management.

Risk assessment in primary care is done for the purpose of determining if a patient can be appropriately managed in primary care or requires referral to specialty mental health services (the MHC for beneficiaries eligible for care, and alternate community resources for those who are not). In cases where the patient is determined to be at moderate or greater risk for suicide, the BHC should arrange for immediate transfer to SMH. If, for some reason, SMH is not available, the BHC must conduct a more extensive assessment of risk (and appropriate crisis planning) in primary care that is equivalent to what the patient would receive if they were seen in the MHC.

BHCs should recall that length of visit is one of the characteristics that distinguish BHOP from traditional mental health. If risk cannot be adequately assessed and managed within a 30-minute appointment, which is the standard of care for BHOP, it may mean that, by definition, the patient's needs exceed BHOP's scope of care and require SMH care. It is certainly not the case that BHCs must immediately refer suicidal patients to SMH as a walk-in if their assessment/management exceeds 30-minutes. BHC's may use clinical judgment along with consideration of their schedule in deciding to spend more than 30 minutes with a suicidal patient. However, BHCs should not feel pressured to strain the limits of the BHOP model in order to avoid such immediate referral based on patient preference, perception that SMH services are too busy to accept the referral, the BHC's desire to avoid referral or other motivations.

The Air Force Guide for Managing Suicidal Behavior: Strategies, Resources and Tools (2002) outlines a model of care for the assessment and management of high-risk patients within specialty MHCs. In addition, suicide risk and assessment is an area that is often overlooked in most BHC texts, leaving little guidance for BHCs when confronted with suicidal patients. Thus, there have been many questions about the appropriate manner in which to assess suicidality within this context. Recent publications (Bryan & Rudd, 2010; Bryan, Corso, Neal-Walden & Rudd, 2009) have begun to address this need by proposing specific practice recommendations for the management of suicide risk within the BHC model. In doing so, they have outlined a model of good clinical care for patients that remains practical, within the boundaries of BHC practice, and is consistent with the Air Force Guide for Managing Suicidal Behavior.

The remainder of this section will outline an assessment and management strategy for use by BHCs. This strategy will seek to optimize the BHC's contribution to the behavioral health care of the population served and individual patients, while recognizing its inherent limits and allowing SMH services to perform their function without inappropriate overlap. The main goals are to provide appropriate, quality service to the patient and prevent well-meaning BHCs from extending themselves beyond their role as consultants to the PCM.



Consistent with the Air Force's focus on suicide prevention, BHCs should screen for the presence of suicidal ideation (SI) at each initial appointment (Bryan & Rudd, 2010; Bryan et al., 2009). The importance of screening for suicidal ideation in primary care is emphasized by findings that, of individuals who die by suicide, 45% (Luoma, Martin & Pearson, 2002) have made contact with their primary care physicians within a month of their death and nearly 20% (Pirkis & Burgess, 1989) made contact within a day of their death. Screening at initial evaluation may be done by direct questioning (e.g., "Are you having thoughts about hurting or killing yourself?") or by a combination of standardized measures that query the presence of SI and, because some patients may not report SI unless asked directly (Rudd, Joiner, & Rajab, 2001), direct questioning. Questions about "suicidal ideation" may be interpreted differently by different persons. When a patient screens positive for SI, the BHC must determine if the patient experiences true suicidal ideation or nonsuicidal morbid ideation (MI), which can include thoughts about death (e.g., "I wonder what happens after death" or "I wonder what my funeral would be like") or wishing to be dead in the absence of suicidal content (e.g., "I just wish I didn't have to wake up tomorrow and feel this way"). The distinction is critical as Joiner, Rudd and Rajab (1997) found that suicidal ideation has a much stronger relationship to suicidal behavior than does nonsuicidal morbid ideation. In general, patients with nonsuicidal morbid ideation do not require further assessment unless they also have a history of suicide attempts. However, each case must be considered individually and BHCs should use clinical judgment to determine the level of assessment required for those with morbid ideation and other risk factors. Those who report current SI always require further assessment.

Screen for SI and history of suicide attempts at each initial contact

Directly ask about SI; may also use a self-report screener

Distinguish SI from morbid ideation (MI)

Screen for history of suicide attempts and suicidal behavior as appropriate

Screening for SI is believed to be consistent with the BHC's role as consultant to the referring PCM. In that role, the BHC is responsible for triaging the patient and determining if their needs can be met in primary care or if referral to SMH is more appropriate. Because managing highly suicidal patients in primary care is beyond the scope of the BHC role, BHCs can only be certain that the patient may be appropriately maintained in primary care after ruling out the presence of suicidality.

Screening for SI is recommended for all BHC follow-up visits (Bryan & Rudd, 2010) regardless of the presence or absence of SI/morbid ideation at initial evaluation. In cases where no SI was present during the initial appointment, follow-up screening may be done with a standardized measure and should be documented appropriately (e.g., "No SI per item # 9 of the PHQ-9"). In cases where SI or morbid ideation has been previously reported, use of direct questioning is important to determine if any changes in the quality, frequency, intensity or content of ideation that would alter risk level have occurred. The screening requirement at both initial and follow-up appointments, applies to patients age 16 and over. The recommendation should be applied to children under age 16 at the discretion of the BHC.

Screen for SI at each follow-up

May use self-report if no SI previously reported  
Screen and assess appropriately by direct questioning if SI or  
MI has previously been reported

Additional assessment of risk is required for those screening positive for SI. Assessment of risk by BHCs should focus on information that is most predictive of suicidal behavior. The sequencing of questions is important as starting with questions with relatively low levels of intensity and sensitivity and progressing to more intense and sensitive questions can increase the accuracy of patients' report (Shea, 2002).

Start by assessing history of suicide attempts. BHCs should assess the specific behavior of the attempt (i.e., overdose, cutting wrist, hanging), intent at the time (i.e., to die, cry for help), why the attempt was unsuccessful (i.e., arranged to be found/rescued, unanticipated rescue), the patient's current thoughts on the unsuccessful attempt (i.e., wishes they had been successful, happy the attempt was not successful, ambivalent) and medical severity of the attempt. In cases of multiple attempters, this information should be collected for the first attempt and the attempt that was the most medically severe. The goal of obtaining this information is to have a snapshot of the patient's behavioral pattern and intent over time as a context for understanding their current risk. BHCs should also screen for history of self-harm, preparatory or rehearsal behaviors (Bryan & Rudd, 2010) such as cutting, burning and taking excessive medications.

If positive for SI

Assess history of attempts (first and most severe for multiple attempters)

How attempted

Why unsuccessful

Medical severity

Current thoughts on unsuccessful attempt

Intent at the time

History of other self-injurious behavior

After assessing history, the BHC should return to the current episode of suicidal symptoms with a focus on resolved plans and preparation (RPP) in order to maximize accuracy of assessment. RPP includes the duration (amount of time devoted to ruminating on suicide each day) and intensity of SI. Sense of courage to make an attempt, availability of means, opportunity to make an attempt, specificity of planning (i.e., has patient identified means, a specific time, place and circumstances for an attempt), preparation and rehearsal are also critical elements of RPP.

For current episode of SI, assess

Duration of SI

Access to means

Intensity of SI

Sense of courage

Opportunity for attempt

Rehearsal

Specificity of plan

Preparation

It is critical to assess barriers to self-harm. If the patient is not immediately transferred to SMH, this information is important in order to build on barriers to create specific, tailored interventions as part of the patient's crisis response plan.

Assess barriers to self-harm  
Incorporate into crisis response plan if patient is  
not immediately transferred to SMH

BHCs must determine the level of risk presented by the patient. Patients with no or one previous attempt are considered to be at moderate risk if they have one significant RPP factor. Multiple attempters, persons having 2 or more previous suicide attempts, should be considered to be at moderate risk if they have significant emotional distress or any level of suicidal indicators.

<u>Determine risk level</u>		
Number Previous Attempts	Criteria	Risk Level
0 or 1	Significant RPP (Frequent SI of moderate intensity/duration; planning; any objective markers of intent, rehearsal or preparation)	Moderate
2 or more	Significant emotional distress <u>or</u> any suicidal indicator regardless of symptom level	Moderate

Patients evaluated as mild or lesser risk for a suicide attempt may be appropriate for management in primary care but should be offered referral to SMH. Those determined to be at moderate or greater risk require further assessment and should be transferred to SMH immediately.

Determine appropriate level of care  
Mild or lower  
Consider for management in primary care  
Offer referral to SMH  
Moderate or greater  
Immediate transfer to SMH

If a patient assessed to be at moderate or greater risk is not transferred immediately to SMH, the BHC must conduct risk assessment and crisis planning comparable to that which would be accomplished in the MHC before releasing the patient. Note that this should be an extremely rare occurrence and only done with SMH is not available (i.e., it is an emergency

situation and the BHC is the only resource for assessment and management). This means that BHCs should be familiar with The Air Force Guide for Managing Suicidal Behavior: Strategies, Resources and Tools (2002) and management options, such as unit involvement, that are unique to the military. The most important management actions to take include adding the patient to the High Interest Log, with Command notification for AD patients, considering the need for inpatient admission, developing a Crisis Response Plan and, with proper consent, engaging members of the patient's social support network. The patient should be transferred to SMH at the earliest possible time.

In most cases, the PCM will retain responsibility for the patient until they are seen by SMH, hence the desire for them to be engaged with SMH as quickly as possible. The primary care team should actively manage such patients until they are seen by SMH and care is transferred. Active management may include more frequent appointments with the BHC and/or phone contacts for status checks. Patients determined to be at moderate or greater risk who are not immediately transferred to SMH should be placed on the MTF High Interest Log, with appropriate command notification for AD, by the BHC, as a consultant to the PCM. Any time a patient is referred for SMH care, the BHC/PCM should follow-up to ensure the patient has engaged with the clinic and document that the transfer of care has been accomplished. BHCs should be aware of patients on the MTF High Interest Log by reviewing the log weekly. They should also be present for high interest case reviews. This may be accomplished by attending the MTF staffing of high interest cases, for full-time BHCs, or by attending the MHC weekly staffing, for BHCs who spend part of their time in the MHC.

If patient cannot be transferred to SMH immediately

- Complete thorough risk assessment
- Place on High Interest log (requires command notification for AD)
- Consider the need for inpatient admission
- Engage in safety planning as appropriate based on risk level
  - Consider a crisis response plan
  - Consider incorporation of social support (with appropriate consent)
- Have frequent contact with patient until transferred to SMH
- Make positive confirmation that transfer to SMH has been accomplished

Some suicidal patients whose needs exceed the scope of BHOP and require SMH treatment may be reluctant to accept a referral to SMH. When a patient requires SMH care but declines referral, the BHC/PCM should clearly document the level of care they believe the patient needs and the PCM should place a referral to the appropriate SMH service even if the patient has indicated that they will decline referral. If the patient requires involuntary hospitalization, appropriate steps should be taken and the BHC/PCM should ensure the inpatient facility is aware that they need to arrange SMH follow-up as part of discharge planning and that the patient should not be return to BHOP for outpatient care. The MHC should be notified any time an eligible beneficiary is sent directly for inpatient psychiatric care by a member of the primary care team. In addition, for active duty patients, their commander should be notified of risk level and recommendations in accordance with AFI 44-109, AFI 44-172, DoDI 6490.4 and DoDD 6490.1.

For patients who require immediate hospitalization  
BHC may help PCM arrange transportation and admission

Cases in which involuntary hospitalization is not warranted but the patient refuses referral to SMH care are more complicated. For AD patients, the BHC, on behalf of the PCM, should consult with the Commander and recommend considering a command directed evaluation. Non-AD patients present even more challenges. While recognizing that a higher level of care is more appropriate, having the patient engaged with the BHC and PCM is preferable to complete disconnection from medical care. Given this context, at each follow-up, the BHC/PCM should inform the patient that BHOP is not the appropriate level of care and that transfer to SMH care is recommended. The patient should be educated about the risks of declining the referral. This should be documented along with the patient's expressed understanding. Every effort should be made to stabilize the patient and manage risk while providing therapeutic interventions to resolve suicidality. However, the primary goal in such cases is to address barriers to accepting the referral for SMH treatment and facilitating the patient's movement into that level of care. This can be accomplished by adopting a problem-solving approach in which the BHC and patient develop goals in a collaborative manner. The BHC can then recommend SMH as a resource for achieving those goals. The BHC may want to suggest that the patient agree to limited involvement (such as 3-4 sessions) with SMH in order to improve motivation. All members of the patient's healthcare team should be informed of the situation and take similar steps to encourage transfer to SMH so that at-risk patients receive a consistent message regarding the need for transfer.

For patients who require specialty mental health care but decline transfer  
See "If patient cannot be transferred to SMH immediately" box above for immediate actions

If AD, consult with command regarding a Command Directed Evaluation

If not AD

Inform patient that BHOP cannot meet their needs and recommend transfer SMH at each contact

Engage in appropriate safety planning

Consider a crisis response plan and incorporation of social support (with consent)

Recommend PCM make referral in AHLTA

Assess risk at each contact

Increase frequency of contacts

Stabilize patient

Use interventions to reduce SI

Address barriers to accepting referral

Management of patients determined to be at mild risk for suicidal behavior in primary care is within the scope of BHOP, though such patients should be offered a referral to SMH care. Follow-up appointments should include assessment of changes in suicidal symptoms and risk level. BHCs will need to reassess RPP to ensure that risk has not risen to a moderate or higher level, which would necessitate transfer to SMH care. The BHC should assess adherence to treatment recommendations and adherence to the crisis response plan if one has been developed. Lack of adherence to the crisis response plan should signal a need to reconsider referral to SMH. These patients may require more frequent appointments with the BHC and/or phone contacts as noted above until risk resolves.

For patients at mild or lower risk

Consider for management in primary care

Offer referral to SMH

Assess SI/risk at each follow-up

Consider use of frequent contacts

Assess adherence to recommendations at each contact

## **ASSESSMENT INSTRUMENTS**

Because consultation services are brief, PCM-oriented, and not a form of specialty mental health care, it is not appropriate to apply traditional clinical intake or outcome assessments. However, we encourage brief, symptom-focused assessments, as well as quality-of-life assessments. Recommended instruments include the following:

Assessments of quality of life, health and mental health functioning:

- Short Form - 36 (SF-36; Ware, Snow, Kosinski, & Gandek, 1993)
- Short Form – 12 (SF-12; Ware, Kosinski, & Keller, 1995)
- Duke Health Profile (DUKE; Parkerson et al., 1990; see Appendix 6)

Screening for depression:

- Patient Health Questionnaire – 9 (PHQ-9; Kroenke et al., 2001; see Appendix 6)
- Patient Health Questionnaire – 2 (PHQ-2; Kroenke et al., 2003; see Appendix 6)
- Geriatric Depression Scale (GDS-15; Friedman, Heisel, & Delavan, 2005)
- Edinburg Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987)

Assessments of general psychological distress:

- Outcome Questionnaire - 45 (OQ-45; Lambert et al., 2004)
- Outcome Questionnaire Short Form (OQS-10; Lambert et al., 1997).

## DOCUMENTATION AND TREATMENT PLANNING

You should record consultation responses and follow-up notes in the patient's general medical chart. You should not create a corresponding entry in a patient's existing mental health folder or create a new mental health chart because of a consultation service. When you recommend referral of a patient to specialty mental health as result of a triage consultation, a copy of the consultation response should be forwarded to be placed in the patient's mental health chart. Alternately, the referral can indicate the presence of the BHOP consultation in the electronic medical record so that the mental health provider receiving the referral is aware that the consultation is available for review. Document all consultation visits in the patient's medical chart. We recommend the Subjective, Objective, Assessment, Plan (SOAP) format, but BHCs should include a second "P" ("Prevention") section if that is required by the local PC clinic or MTF. See Appendix 8 for sample notes.

Some BHCs have found it useful to number specific recommendations under the first "P" (Plan) of the SOAP note. In addition, we recommend clear, concise documentation of what you are asking the PCM to do in follow-up contacts with this patient. Some BHCs even recommend placing this at the beginning of the SOAP note, so the PCM can easily access the information.

When using the AFMS electronic medical records system, AHLTA, you may create and use templates for documentation of BHC services.

### Initial Consultation Response

In general, your initial consultation response should contain the following information:

- Who requested your involvement and the referral question, if applicable. If the patient came without a PCM referral, include the name of their PCM.
- A statement of your pertinent assessment findings (e.g., symptoms of mental disorder, life stresses, functional impairment, relevant psychosocial issues)
- A brief mental status including documentation of the presence/absence of SI/HI
- Your clinical diagnostic impressions. A diagnostic formulation is not required; however, you should include a diagnosis in cases where a patient does meet diagnostic criteria, or when a diagnosis is suspected (provisional). It is not necessary to use the complete DSM-IV multi-axial (5 axes) system. In instances in which the BHC provides services related to a medical or physical condition (rather than a mental health disorder), the medical condition may be coded (e.g., headache, diabetes, obesity).
- A statement of your recommended interventions and who is to execute them (e.g., consultant, healthcare provider, patient)
- A statement of the follow-up plan (e.g., no further consultation planned or patient will return in a specified period of time for consultative follow-up)

**NOTE:** As your initial contact is consultative, you *must* write the plan as recommendations.

While the complexity of a particular case influences the length of notes, a typical consultation summary is brief, preferably one page or less. Healthcare providers prefer focused, brief responses that offer simple, straightforward recommendations.



## Follow-up Consultation Notes

Consultation notes for follow-up BHC appointments are also recorded in the medical record. Follow-up notes are typically shorter than initial reports (see samples in Appendix 8). Document each follow-up as an encounter, although you are still acting in a consultative role, performing a consultative follow-up. Follow-up notes should contain:

- A statement that this is a follow-up visit and the approximate time since the last visit
- Your assessment of the patient's adherence and response to interventions initiated by you and/or the healthcare provider
- A brief mental status including documentation of the presence/absence of SI/HI
- Diagnostic impressions
- Your recommendations on continuing or modifying intervention strategies, including clear statements of who is responsible for executing intervention strategies (e.g., you, the patient, the healthcare provider)
- A brief statement of your follow-up plan, including when the patient should return to the PCM or the BHC for additional follow-up

*See Appendix 8 for sample SOAP notes.*

## DOCUMENTATION OF SENSITIVE ISSUES

Since medical records are fairly open and accessible, you must balance concerns about documenting a sensitive issue in the record with the needs of other healthcare providers to know certain information. You can communicate sensitive information to the patient's PCM in a variety of ways, including phone follow-ups, and you need not always document them in the medical record. You should document all information directly pertinent to the provision of care in the medical record. The BHC should employ the same guidelines a mental health clinic uses in determining when to place a patient on a medical profile or limited duty for mental health concerns (e.g., temporary removal from Personnel Reliability Program [PRP] status). You should also communicate this information appropriately to the patient's PCM.

**NOTE:** You *must* comply with regulations regarding reportable events, regardless of its sensitivity. ***The provider who identifies the reportable event is responsible for acting on the information.*** You should not push this responsibility onto the PCM if you identify the event. Similarly, you should not accept this responsibility from the PCM if the PCM identifies the event.

## PROVIDING FEEDBACK TO THE PCM

Since the hallmark of primary behavioral health care is to serve as a consultant to the PCM, providing feedback to the referring PCM is one of your most critical roles. We encourage you to provide feedback *in person* and on the *same day* you see the patient. Written feedback will come in the consultation response. However, once it is entered in the medical record, it may be some time before the referring PCM sees that patient's record again. You have several options for feedback: verbal (in person or voice mail), e-mail (only over a LAN or secure channels), or copying the consultation response directly to the referring PCM. In practice, some combination of these options is likely, and providers may prefer one method to others. The *only* critical aspects of delivering feedback are that it be *succinct* and *timely*.

## MISSED APPOINTMENTS

If a patient does not keep an initial or follow-up consultation appointment, the BHC should notify the PCM and document the "no show" in the medical record. Including a statement such as "Patient referred by PCM for chronic pain did not show for initial consultation appointment. PCM may refer patient again in future, if indicated" is appropriate.

Standard processes in primary care place primary responsibility on patients to reschedule missed appointments. Consistent with this PC practice, BHCs are not required to call patients who have missed BHC appointments. However, if the BHC has information suggesting that the patient may be at heightened risk for self-harm (e.g., information in medical record or from PCM indicating suicidal ideation), *the BHC should use appropriate clinical judgment in attempting to reach the patient to reschedule a BHC appointment.*

## **TERMINATION OF CONSULTATION SERVICES**

Patients in primary care receive longitudinal care from their PCM throughout the lifespan. Consistent with this model, they may see the BHC for “episodes of care” at various points during their life as problems arise. When a given “episode” of consultation with the BHC is complete and no further BHC appointments are planned, the BHC should communicate this to the PCM and document the recommendation in the chart. Consultation notes should include recommendations for the healthcare provider, including monitoring of risk factors and implementing relapse prevention strategies at future medical appointments. Future consultation with the BHC would be available for a recurring or unremitting problem, or for assistance with a new problem.

*Appendix 7 provides a summary of the primary guidelines for delivering BHC services.*

# **Chapter 5: Administrative Procedures**

## ADMINISTRATIVE OVERVIEW

### Medical Expense Performance Reporting System (MEPRS) Codes

In an effort to standardize MEPRS coding across the Department of Defense, the “B\*\*W” codes that were formerly used to identify BHOP work in the Air Force have been eliminated. As of October 1, 2009, BHCs should use the MEPRS code for the clinic in which they provide services. The only exception to this rule is that work accomplished in Family Health clinics should use the code “BGAZ.”

In accordance with the above guidance, the following MEPRS codes should be used for BHC work in these medical clinics:

MEDICAL CLINIC	MEPRS CODE
Family Health	BGAZ
Flight Medicine	BJAA
Women’s Health and OB/Gyn	BCBA
Internal Medicine	BAAA
Pediatrics	BDAA

This process allows the primary care administrative staff to have full access to your appointment template to book patients in the Composite Health Care System - II (CHCS) or AHLTA.<sup>2,3</sup> Work done by BHCs can be distinguished from that of physicians working in primary care clinics. This is important for determining actual workload for BHCs who work in primary care part-time. Local Data Quality Managers, MEPRS Managers, or Data Analysts can query CHCS (ADS), EAS IV and/or M2 using specific provider codes for social workers (code 702), psychologists (code 703) and psychiatric nurse practitioners (code 611) to obtain this information.<sup>4</sup> You can determine your total productivity by summing your primary care MEPRS workload and your mental health clinic MEPRS workload.

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<sup>2</sup> BF\*\* MEPRS templates are open only to authorized persons, such as mental health technicians. Therefore, using a BF\*\* MEPRS code will cause substantial access barriers to booking BHC appointments.

<sup>3</sup> At some facilities, using this combination of MEPRS codes may inadvertently open BHC appointments through central appointments. You must ensure that primary care staff can book your appointments, but that central appointments cannot.

<sup>4</sup> Originally, mental health leaders were somewhat concerned that work performed by providers assigned to the mental health clinic would be “attributed” to the primary care clinic in this model; however, the recommended process addresses this concern.

## ADS Coding

One of the most common services you will provide as a behavioral health consultant is consultation to the PCM, although you cannot enter or track these “indirect” services through ADS. However, when you provide *direct mental health services* to a patient in primary care, you must correctly use ADS codes for each encounter, to record it accurately. It is important that you complete the ADS codes for all *direct services* with *specific codes*. You complete the ADS codes as part of your AHLTA documentation. Coding guidance differs for BHC services compared to specialty mental health services. Appendix 10 details guidance for coding the work done as a BHC.

*Appendix 10 details the ADS coding guidelines, and provides a glossary and recommended prototype template for local adaptation.*

## BHC SERVICE DEFINITIONS

Generally, the distribution of services you offer should reflect 1) the level of morbidity for physical and behavioral health in the PC panel, and 2) the proportion of panel members expected to “penetrate” the service. For example, a well-designed set of psychoeducational classes that protects the BHC from “caseload clog” may better serve panels with high morbidity and service use. Similarly, you may devote a higher percentage of your available services to continuity consultations, to help the PCM team manage those patients unwilling to participate in psychoeducation-based management.

### The BHC Brief General Consultation Visit

The BHC brief general consultation visit is the backbone of your role and, in most service settings, will be the predominant appointment type for both new and established patients. The brief general consultation visit is based on a service philosophy of “see all comers.” Primary care providers are encouraged to refer all potential patients with behavioral health needs to the BHC, who will ordinarily have a combination of scheduled and “on-call” time available. These visits are short, typically 30 minutes, and limited in number. Typically, you will focus on practical problem solving or providing consultative recommendations to the primary care provider. The brief general consultation visit may occur conjointly with a primary care provider. In all cases, it will result in some type of consultative feedback to the patient’s PCM. This brief, general, problem-solving approach will best serve most patients in a primary care cohort.

### The BHC Psychoeducational Class Visit

The BHC psychoeducational visit is for high-frequency primary care populations, such as those with depression, anxiety, or chronic diseases, where a group or classroom approach may

help supplement, or even replace, individual visits. In most clinic settings, you should strive to have ample group and classroom programs available, to minimize an excessive demand for individual visits. You can better treat many patients in group or classroom programs, and this option allows them to have more regular contact with services, with very little impact on overall program costs. (Initially, you will not need to minimize individual care, as you establish the service in a new clinic, and you should heed patient choice.)

### **The BHC Continuity Consultation Visit**

The BHC continuity consultation visit is for patients you see more than 4 times, and who have chronic psychosocial and/or physical problems requiring longer-term management by the primary care team, in consultation with the behavioral health specialist. Commonly, patients with personality disorders, chronic pain/disability issues, or treatment- and lifestyle-compliance issues involving a chronic medical illness need this service. You deliver the program using the BHC-visit service model, but spread out the appointments. The goal of this service is to help the primary care team efficiently manage the patient's health and behavioral health needs. It ordinarily involves creating a utilization plan and focusing on restoring adaptive functioning, rather than eliminating an acute mental disorder.

### **The Telephone Consultation Visit**

The telephone consultation visit is a clinical encounter with a patient to perform some assessment and/or intervention. We encourage scheduled telephone contacts as a low-intensity means of maintaining contact with patients whose visits likely will be at longer intervals than traditional mental health appointments. We encourage you to view telephone contacts as legitimate opportunities for meaningful clinical interactions to promote behavioral changes. You can also use telephone contacts as routine follow-ups. Since the percentage of BHC contacts via telephone is unknown, we have accounted for them in the BHC visits in Table 4, which summarizes BHC service definitions.

**NOTE:** You should document all patient telephone consultations in the medical record, including appropriate ADS coding.

While we have organized BHC services around these core types, in practice you will deliver a wide variety of valued services to patients on behalf of PC providers. [See the section titled Typical BHC Services in Primary Care](#). It is designed to show the rich array of services the BHC may develop and delivery locally, and is certainly not exhaustive.

**Table 4: BHC Service Definitions**

Visit Type	Estimated Percentage of BHC Contacts	Key Characteristics
Brief general consultation and telephone consultation	60-70%	Brief, general; oriented to a specific referral issue from health care provider. Visit length (30 minutes) matches pace of primary care. Provides brief interventions, and supports medical and psychosocial interventions by PC team member. May involve conjoint “exam room” visit with PCM. May primarily focus on psychosocial condition or behavioral sequelae of medical conditions. May include telephone contact.
Psychoeducational Class (condition management)	10-20%	Usually focused on high-cost and/or high-frequency health or psychological conditions. Employs psychoeducational approach in classroom or group modality. Intervention is often highly structured, with condensed treatment strategies; emphasis is on patient education and self-management strategies.
Continuity consultation	10-20%	Reserved for high utilizers and multi-problem patients. Emphasis is on containing excessive medical utilization, giving PC providers effective behavioral management strategies and community-resource case management. Goal is to maximize patient’s daily functioning, not necessarily symptom elimination. Service is long-term, but does not involve intensive treatment; visits are brief (30 minutes), infrequent, and regularly scheduled.

## SCHEDULING TEMPLATES

All service templates should be set up in **30-minute increments**. The primary care administrative staff will maintain scheduling templates, not individual providers. However, all professional staff also should have access to schedules.

Some appointments, particularly follow-up appointments, may not require the full 30 minutes. You may opt to schedule these in 15-minute increments, or simply use less than the 30 minutes for your appointment. The time spent with the patient should be accurately documented and coded.

## SCHEDULING STANDARDS

Per the AFMS Guide to Mental Health Business Practices (2009), providers working full time in primary care or other medical clinics should generate 40 RVUs per week. An average of seven to eight 30 minute encounters per full day will generally meet this standard. This will allow sufficient time to provide the consultation to primary care providers which is the hallmark of primary behavioral health care, as well as time to participate in primary care staff meetings, case conferences, case management meetings, peer review, outreach, etc. Those working part time as a BHOP provider will generate 40 RVUs with a mix of BHOP and Mental Health Clinic work. BHOP providers will typically generate 4 RVUs per half day working in a primary care setting.



BHCs are encouraged to leave some open time in every scheduling template to allow PCMs access to same-day appointments for any patients presenting with acute symptoms. PCMs and BHCs have found this type of scheduling desirable. However, BHCs will still be expected to meet productivity standards described above when leaving appointments open for same-day access. This means that BHCs will have to ensure that same-day appointments are utilized effectively.

Overall, BHCs should strive for flexibility in their schedules. Patients may be seen for less than 30 minutes if necessary or indicated. The BHC should attempt to “work in” a patient at the request of a PCM, whenever possible (even if there is not an “open” or “administrative” time slot immediately available).

## TECHNICIAN SUPPORT

Currently, mental health technicians do not play an on-site role in delivering primary behavioral health care services. However, for this service to succeed, they likely will have to play a more active clinical role in the mental health clinics. This may increase the efficiency of the mental health clinics, thereby allowing providers to spend time in primary care. Each site will determine the specific ways of enhancing the roles of mental health technicians.

*See also staffing guidelines at end of this chapter.*

## DOCUMENTATION

The outpatient medical record is the official, primary, clinical record for BHC services. A separate mental health record for patients should not be used. You will enter documentation in AHLTA to reflect the delivery of services as a behavioral health consultation in primary care. Notation shall be brief, using [recommendations for documentation](#) in Chapter 4. We recommend that you use a different signature block reflecting your role as a behavioral health consultant, rather than a specialty mental health provider. Someone reviewing this chart for clearances, for example, may consider this a “mental health” note, so it will be useful to draw a clear distinction between BHC services and specialty mental health.

## INFORMED CONSENT AND COUNSELOR DISCLOSURE STATEMENTS

A formal, written, informed-consent document is neither required nor recommended for BHC services. [Please refer to the summary of United States Air Force (USAF) legal opinion on page 2 of this manual.] Remember that the “standard of care” for specialty mental health clinics **does not apply** to BHC services provided in primary care. The comparison for the BHC service “standard of care” is what patients receive in a primary care clinic. Since primary medical care does not currently include BHC services, we should not compare it to that provided in a mental health clinic. We acknowledge that by simply providing behavioral health services in primary care, we are expanding the scope of services. Inherent in this is some increased risk of liability. However, other large healthcare organizations have determined this risk to be minimal compared to its benefits, and have set a precedent for using a standard, verbal disclosure. The AFMS is following this precedent.

You **will** do all of the following in an initial contact with any potential BHC patient:

- Inform the patient of whom you are and that you are a behavioral health provider.
- Inform the patient of the limits of care you can provide (i.e., consultant only).
- Inform the patient that you have the same reporting obligations, particularly for active duty members, as any other medical provider. (This information appears on the standard, written, information sheet.)
- Inform the patient that you will communicate with their PCM regarding the content, findings and recommendations that arise from BHC appointments
- Give the patient the required standard BHC information sheet (see Appendix 1), if the patient does not have it already, and address any questions they may have about it.
- Strive to develop trust and open communications with the patient.

Following is a prototype for a verbal, introductory script. Use this script, or something similar, to ensure that the nature of BHC services is clear to the primary care staff and all potential patients. This disclosure statement is also included in Appendix 2.

### Behavioral Health Consultant Introductory Script

Hello, my name is \_\_\_\_\_.

Before we get started today, let me explain to you a little bit about who I am and what I do.

I’m the behavioral health consultant for the clinic and a (psychologist/social worker/nurse/psychiatrist) by training. I work with the primary care managers in situations where good health care involves paying attention not only to physical health, but also to emotional health, habits, behaviors, and how those things interact with each other. If your provider is concerned for any reason that any of these factors are affecting your health or functioning, they can call me in as a consultant.

**My job as a consultant is very specific. It's to help you and your provider better target any problems that have come up for you at this point. To do this, I'm going to spend about 25 minutes with you to get a snap shot of your life—what's working well and what's not working so well. Then together we'll come up with a plan or set of recommendations that seems doable.**

**The recommendations might be things you try on your own, like reading some self-help material, practicing some skills on your own, and you might never see me again. Or, we may decide to have you come back to see me a couple times, if we think that would be helpful to get some positive momentum going on specific skills. We might also decide that you'd benefit from going to a more intensive specialty service. In that case, I'd talk with your primary provider and, if that was something they wanted for you, I'd help them arrange a referral, using the information you've given me today.**

**After we've finished meeting today, I'll meet with your provider to go over what we've talked about and what the plan is. This information will be integrated in your healthcare record. So, don't be surprised if your provider, or any other health care team member, asks you how parts of the plan are going.**

**My limits of confidentiality are the same as other providers in this clinic, which includes responsibility to report cases in which someone is a risk to themselves or others and cases of domestic abuse or violence. (For active duty members, I may also be required to report UCMJ violations.)**

**Do you have any questions about any of this before we begin?**

**If yes: Spend time needed to make sure the patient understands the purposes of this service.**

**If no: “(medical provider's name) is concerned about (referral reason). Is that your sense of what is going on here, or do you have another take on this?”**

## RECOMMENDED PROCESS FOR USING BHC INFORMATION SHEET

Ideally, BHC information sheets should be readily available to all patients seen in the primary care clinic. You can best accomplish this by placing them in the primary care waiting room and all PCM exam rooms. You should educate PCMs on the recommended process.

At the point of referral to the BHC, the PCM should briefly describe your role and hand the information sheet to the patient. This allows the patient to learn about the service at the time of referral. He or she then can read the sheet and generate questions before their appointment with you. At the start of the appointment, you can ask whether the patient has any questions or concerns about what they have read. If the PCM has not provided the information sheet, you are responsible for doing so. In such cases, you may also need to cover more of the verbal script. Regardless, you must ensure that ***all patients have received and can verbalize an understanding of the information*** in the sheet. Each BHC must decide whether to document in writing that the patient has received and expressed an understanding of this information. However, we expect this process to become a routine part of your practice; we assume that all patients in the BHC service have received it and been given an opportunity to discuss it.

## INTERVIEW SUGGESTIONS FOR INITIAL CONSULT

In the first 15 minutes, you should give the introduction and conduct an interview assessing symptoms and functioning, using the following questions as a guide, when appropriate. This leaves 10 minutes to discuss and start interventions, and five minutes to write a note, go to the bathroom, etc. Take 20 to 25 minutes to assess functioning, if you must. It is probably better to get all the information you need, to avoid making shortsighted recommendations. However, when possible, gear your data collection to get the information you need in about 15 minutes.

- What is the referral problem? (And does the patient see this as the main problem, or is there something else?)
- Is it a short-term or long-term problem?
- How intense and frequent is the problem?
- What does the patient do that makes the problem better or worse?
- How does the problem functionally impair the patient?
  - Any changes in work performance?
  - Any changes in work relationships?
  - Any changes in significant familial relationships (spouse, children, etc.)?
  - Any changes in social activities (going out with friends, church)?
  - Any changes in engaging in fun/recreational/relaxing activities?
  - Any change in exercise? (If stopped, what exercise? How long ago did they stop?)

- Any changes in mood, interest, sleep, energy, concentration, appetite?
- Any suicidal ideation?
- Do they consume caffeinated drinks? (If so, how many a day? How many ounces each time?)
- Do they consume ETOH? (If so, how many per sitting? How many ounces each time?)
- Any over-the-counter medications or supplements?
- Ask the patient to describe what a typical weekday is like for them. What does a typical weekend look like?
- Summarize your understanding of patient's problem.
- If patient says you have a good understanding of the problem, ask if they would be interested in learning how to change one or two things that they control to help them function better. Then proceed to treatment recommendations, taking into account as priorities what they just said.
- It is OK to have no recommendations other than the patient continuing to engage in behaviors and thinking styles that are currently working.
- If you have several recommendations, list all of them to the patient, and describe how they might help them function better. Then, ask them which seem doable.
- Once you have decided on recommendations, write them out, if possible or appropriate. Then, determine whether a follow-up appointment would be useful to help assess the success of the plan or teach additional skills, and have the patient schedule it.

## STAFFING GUIDELINES

We based the original BHOP staffing projections, from recommendations by the behavioral health consultants to the AF Surgeon General, on the number of mental health provider full-time equivalents (FTE) at each location. However, experience from the first year of BHOP caused us to reconsider them. We base the current recommendations on that experience and an algorithm the civilian sector commonly uses to allocate BHC resources to panels of primary care enrollees. Specifically, **we recommend two BHC hours per week, per 1,000 TRICARE enrollees to a primary care clinic.**<sup>5</sup> The Health Care Integrator at your primary care clinic should be able to provide you with current enrollment statistics.

Additionally, experience suggests that patient demand will increase. **We advise initially allocating fewer BHC hours to primary care (approximately one hour per week, per 1,000 enrollees).** You should reasonably expect a slow start-up phase, while you become comfortable and the PCMs become more aware of available services. Therefore, we recommend that sites do not fully allocate providers according to this model until service demand increases. The time required for the service to mature will vary, but you can monitor it to determine when you can justify an expansion. Finally, as sites mature and incorporate a clinical pathway to detect and manage depression in primary care, for example, we recommend increasing to approximately three BHC hours per week, per 1,000 enrollees.

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<sup>5</sup> This algorithm is based on the current BHC model that includes only horizontal integration (i.e., general consultative services). As BHC services evolve and add vertical integration pathways, such as the depression management clinical guideline, expect to allocate up to one additional BHC hour per week, per 1,000 enrollees.

**NOTE:** These are only recommendations and estimates. Systematic and rigorous monitoring is the optimum way to determine appropriate staffing levels.<sup>6</sup>

As integrated care slowly evolves, most of you will work part-time in primary care. A few key guidelines for part-time placement are:

- You should spend no fewer than eight hours per week in the primary care clinic.
- The same BHC should work in the clinic every week.
- You should be in the clinic at the same times, on the same days, consistently.

By following these guidelines, the medical staff will get to know one provider and when they are available on-site.

## **PROGRAM EVALUATION**

Program evaluation is a key component of the ongoing success of any BHC service. First, demonstrating positive results from an evaluation can be essential for obtaining or maintaining leadership support. It may even be necessary for maintaining your BHC service among competing priorities. As they say, when it comes time to make difficult decisions, he or she with the data will win! Second, program evaluation can help you identify areas for improvement, to better meet the needs of both PCMs and patients. Finally, the lessons you learn from a program evaluation at your clinic may be very helpful to others as they implement BHC services. Behavioral health optimization is an innovative method of care delivery in the AFMS, and the more we study it, the stronger our programs will become. You can implement a number of different outcomes or metrics to evaluate BHC services, and we will discuss a few here. Your BHC mentor is an excellent resource for developing a specific evaluation plan.

### **Customer-focused Evaluation**

Some of the most important outcomes for this initiative's goals are customer-focused measures, such as satisfaction. Although satisfying your two primary customers (the PCMs and the patients) alone will not ensure the viability of integrated care, any other outcome will be meaningless if those we are trying to serve do not like what we are offering. Patient satisfaction is paramount, particularly among enrollees other than active duty members, who are being offered more options for healthcare services. Likewise, providers will not refer patients unless they are satisfied with the responsiveness and quality of your services. To that end, we have provided two satisfaction measures in Appendix 12. BHCs used them to examine patient and provider satisfaction in the initial phase of the BHOP.

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<sup>6</sup> Although the BHC may need to spend more time in the PC clinic with the inclusion of a depression management pathway, the role for nurses and mental health nurses in this care will increase, such that the BHC's workload may not change substantially. Again, each site will have to monitor workload and productivity to determine the best way to allot time.

## Quality Assurance

Another evaluation component is how well your program and your work as a BHC conform to AF standards. You can help ensure program quality by using the forms in Appendix 13 (BHC Peer Record Review) and Appendix 14 (Recommended Self-Audit form). The peer-review form is simply a way to use AF standard criteria to evaluate the quality and consistency of your documentation. BHC services are addressed under the Health Services Inspection (HSI), but not the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) assessment. HSI criteria (IG.2.4.2.) for BHC services currently are quite minimal, focusing on having a policy guideline in place that is specific to the MTF (e.g., a Medical Group Instruction; MDGI), that includes a contingency plan to cover mental health provider shortages, and evidence that patients on antidepressants are assessed for suicide risk at every primary care appointment. The BHC self-audit form is more comprehensive and can be used internally to ensure your service conforms to pertinent AF recommendations. If you develop your service to meet these criteria, you should be well prepared to demonstrate that your service meets established AF standards.

## Clinical Outcome Evaluation

Program evaluation can also measure the clinical success of your BHC services. This is akin to the pre/post assessments some specialty mental health clinics employ. Based on the nature and types of services offered in primary care, as well as the stated goals of this type of health care, only assessments of global functioning or quality of life, or specific symptom measures would be appropriate. Instruments that assess comprehensive psychological variables (such as the MMPI, MCMI, etc.) are not appropriate for primary care. Due to the nature of primary care services (i.e., limited number of visits and brief duration of consultative interventions), the instrument must be appropriate, in sensitivity to change and recommended frequency of reassessment, to this level of care. There are a number of brief, standardized assessment instruments that are recommended for use in primary care (see section “Assessment Instruments” in Chapter 4). You can administer these instruments at initial visits and again at the final visit, or at every visit, or some standard, post-intervention timeframe.

## Practice Management Evaluation

Finally, you could monitor a number of metrics related to the functioning of your BHC service. We suggest some metrics to answer specific questions about your practice management in Table 5. You can monitor some of these yourself, or query ADS data to examine your workload and patient encounters (types and numbers).

**Table 5: Practice Management Metrics**

QUESTION	METRIC
Are you allocating the appropriate amount of time in the clinic?	<ul style="list-style-type: none"><li>• Percent of free time on schedule not filled with same-day appointments</li><li>• Time lapse from PCM referral to initial BHC contact</li></ul>
Are you referring outside the PC clinic at a reasonable rate?	Percent of initial visits referred to specialty care per month
Are you seeing patients, on average, a reasonable number of times?	Percent of patients seen in 1-4 appointments

# **Chapter 6: Recommendations for Clinical Practice**



## CLINICAL PRACTICE ISSUES: IS IT JUST A “ROSE BY ANOTHER NAME”

This chapter gives both new and experienced consultants a framework for their services. Along with the rest of the practice manual, you will use this practitioner’s guide in conjunction with *in vivo* training and supervision, to ensure consistent and high-quality service delivery.

Previous chapters have discussed several themes with implications for your clinical activities. Chief among them are the concepts of primary behavioral health as a unique form of service, adopting a primary care treatment philosophy, and operating from a consultant model. In addition, the realities of primary care require a host of specific strategies for “fitting in” that make further demands on your clinical practice style. This chapter examines the most important issues affecting clinical practice in this new model.

### THE GESTALT OF PRIMARY CARE

You must appreciate the differences between the atmospheres in primary care and specialty mental health care. When a patient enters a doctor’s office, they expect to be prodded, poked, measured, advised, handed pamphlets, and asked to do something about a medical problem or to improve general physical health (e.g., cut down on salt intake, see a nutritionist, etc.). ***Primary care is largely an action environment.***

In contrast, patients entering specialty mental health hope that things will change for the better, but believe that talking about the possibilities of, and obstacles to, potential change is required first. When patients cross the “mental health threshold,” their vision of what it takes to reach a solution changes with them. This makes specialty mental health largely a verbal enterprise, characterized by a focus on therapist/patient fit, rapport building, and the verbal analysis of problems and potential solutions. ***Specialty mental health is largely a reflective environment.***

The immediate implications of these differences are that 1) the rules governing patient/provider interactions in primary care are substantially different, and 2) primary care patients have a heightened readiness to do the things providers advise them to do. An associated, major, practice-style change is that it is acceptable to “barge right in” with a patient by saying, “Dr. Jones is concerned about whether you are depressed. Do you see it that way, or do you see something that we need to address?” Another practice variation is that patients expect to leave the primary care clinic with something in hand—a treatment plan that targets their symptoms or conditions. Effective BHCs recognize these practice variations quickly and adjust their style accordingly. Here are some tips.

## **IMPLEMENTING A GENERAL CONSULTATION PROGRAM: A PRACTITIONER'S GUIDE**

Many potential obstacles may stand in the way of implementing an effective, integrated, behavioral health program: the ever-present fear of change, mutual stereotyping, concerns about lacking the necessary clinical skills to achieve integrated care, and the potential for turf struggles over who is the “expert” and who is in “control” of a patient’s destiny. Finally, there is the issue of developing a shared sense of risk-taking, and the associated logistics of sharing space and other support resources. This list is certainly not exhaustive, and the “symptoms” of resistance vary both within and between health and mental health care providers.

Generally, integration proponents have made too much of the “biomedical” versus “biopsychosocial” backgrounds of health and mental health care providers (Pace, Chaney, Mullins, & Olson, 1995). Occasional disagreements might arise over strategies for dealing with a specific patient, but these can occur in an atmosphere of mutual respect and genuine dialogue. As a rule, primary care is pragmatic and outcome-oriented. If your services are concrete, understandable, and result in good patient outcomes, medical providers will accept you. This requires a number of strategies, in addition to being a competent behavioral clinician.

### **Learn to Address Medication Issues**

BHCs need to be knowledgeable about psychotropic medications. BHCs may help patients understand and manage side effects of medications, assist patients in taking medications as prescribed (e.g., avoiding premature discontinuation, adhering to correct dosing schedule), and discuss medication issues with prescribing providers. Several pharmacotherapy “handbooks” are on the market that can help address medication issues.

PCMs may ask your opinion regarding use of psychotropics. In a consultation role, non-prescribers are not required to offer opinions and may advise the PCM to consult with a CLP to help make a medication decision. In all cases, the BHC should not function beyond his or her scope of practice as a non-prescriber. Non-prescribing BHC’s assessment and intervention plans should not include recommendations on specific types and dosages of psychopharmacology. Non-prescribing BHCs can make recommendations about whether a patient may or may not be appropriate for pharmacological intervention. See Appendix 3 for additional guidance regarding the role of the BHC in medication consultation and management.

Additionally, BHCs should be knowledgeable about outcome research of pharmacotherapy and behavior therapy, in order to provide consultation that may increase PCM and patient understanding of the value of behavioral interventions that may be considered in addition to, or in place of, pharmacotherapy.

### **Get Your Foot in the Door**

While management will lay the groundwork, you must be willing to “give your services away” without any real expectations, knowing that the program eventually will sell itself. In some respects, just showing up and getting started (obviously with the required lunch-time meeting with the clinic chief and manager) is not really a “give away” because the primary care site will provide a great deal of infrastructure support (e.g., space, scheduling, chart pulls, etc.).

Ordinarily, this will be the starting arrangement, even if the mental health department is located in the same site. There is a big cultural shift in starting to practice on the primary care “playing field,” so be open to working with even minimal support, to begin showing the long-term value of your services. We encouraged you to establish a relationship with the clinic nurse managers and other support staff on the PCM team.

## **Act like a Guest**

A common sticking point for many mental health clinicians entering primary care is feeling entitled to special recognition or treatment. Often, this means expecting a fixed office space, well-written referral questions from PCMs, having 100 percent of medical charts available, or assuming that PCMs will “track you down” to learn what you thought of a particular patient. An alternative belief is, “I am a guest here. My job is to take what is given to me, and make it work.” Seek out the PCM to offer an update on a patient; chances are, he or she will appreciate it! Be respectful of the time of all members of the PC team. Administrative and nursing staff, as well as PCMs, are busy. Ideally, a well-functioning BHC service will free up time of PCMs and nurses, as the myriad of behavioral health concerns that surface in primary care become better managed. Nevertheless, particularly as you initially establish a service, be sensitive to the extra time it takes for PC staff to accommodate your presence. Keep your requests reasonable, and thank them often for their assistance.

## **Be Flexible**

Working in primary care is a study in cognitive flexibility. Not only do you engage in radically different forms of intervention, but also the context constantly shifts. You must feel comfortable seeing patients assigned at the last minute, most of the time without a chart and only a verbal referral. You may work in a different office space at each visit. You may not always have immediate access to a computer or printer. Sometimes, a staff member will ask to see you over your lunch hour. Other times, you may be paged or called by a PCM with an “urgent” question during your time in the specialty mental health clinic. A PCM may show up to “sit in” with a patient, without discussing goals in advance. You will have to “ferret out” those goals during the consultation. All of these events, and many more like them, characterize a BHC’s life. Your ability to be flexible increases your value to the PCMs and strengthens the services you provide.

## **See All Comers**

Initially, you must remove any artificial barriers that would deter PCMs from referring patients. You cannot demonstrate the value of your services if they occupy a small niche, or if the majority of providers do not use them. Practically, this means telling PCMs to refer any patient for any behavioral health need. It may be helpful to give PCMs examples of “typical referrals,” either verbally or in writing. Make a point of selecting examples that span the vast spectrum of psychological, behavioral, and physical problems PCMs address. A common pattern is for PCMs to initially refer the patients with the “most difficult” mental health problems. In addition to seeing these patients, let the PCM know that you can also see individuals who are “at

risk” of developing future problems, or who have medical problems affected by behavioral or emotional factors, or who are not adhering to medical recommendations, etc.

## **Eliminate “Guesswork”**

Try to instill in PCMs the principle, “When in doubt, seek consultation.” The message is to avoid agonizing over what an appropriate referral is. If several BHCs are present, the healthcare provider shouldn’t have to choose between them. For example, an early consultation model involved pairing a consultation/liaison psychiatrist with a behavioral psychologist in several primary care clinics. During the initial discussion with the healthcare staff, some worried aloud about knowing to which provider they should send a patient. The answer was that consultants are essentially interchangeable; any specialty triaging will occur at the consultation visit itself. As small as they look, any of these issues could promote extra work for the PCM and diminish interest in using the service.

## **Privacy? There Is No Privacy**

Primary care places less importance on privacy. Doctors are interrupted continuously during their exam visits. Nurses, technicians, and others ask them to sign lab orders, discuss a telephone call, or resolve a prescription problem. You must understand this culture and throw away your “Do Not Disturb” door hangers! Nurses will enter your office during a consultation to look for a patient’s chart, or a worker will come in to quickly fertilize and trim plants. Ironically, primary care patients, who have lived through all of this many times, don’t see it as an interruption. It’s just life in a doctor’s office. We recommend that you specifically tell PCMs that it is alright to interrupt you, even when your door is closed.

## **Networking with the Staff**

Like most offices, an informal staff structure really runs things. Administrative staff can find that empty office, go out of their way to fix a scheduling problem, and perform a myriad of other problem-solving operations that can make life easier. In general, the nursing and administrative support staffs are the backbone of primary care practice. Because of the discomfort of being a “visitor,” some mental health providers withdraw into their offices and fail to initiate these relationships. A general rule: When you have an open space in the daily schedule, walk around the office, say hello, and talk to members of the nursing and office staffs. When problems arise, good will pays off. This same principle applies to getting the “inside scoop” on challenging or high-utilizing patients. Given the rapid turnover among military members, some of the civilian staff may be the most useful for patient background information.

## **Know Where PCMs Are, and When**

.Staff members have set, daily routines, and it is important to know them. You can talk to the PCM without as much interruption during “dead spots” in the daily track meet. Remember that part of the culture is to interrupt, if needed, during office exams, but these discussions generally will be very short and to the point. Down times in the PCM’s daily schedule are best to discuss recent cases and provide mutual follow-up information. In PCM groups, lunchtime is often their only opportunity to discuss complex cases. It’s a good time to discuss general problems in the

consultation service, problem cases, or share training on important behavioral health issues. Obviously, these discussions are to highlight the value of referring patients to the behavioral consultant. You will also want to know when staff meetings and provider meetings occur, and make it a priority to attend.

## **Be Proactive, But Not Pushy**

Once you know the PCM's general schedules, approach them during down times to discuss a case or the BHC service. Don't distract them from their jobs, and don't necessarily expect them to seek you for more information about your services. A few may be extremely supportive and do just that, but others will likely be hesitant or skeptical about what you can bring to primary care. For those skeptics, the answer is not didactic sessions or briefings about your services, or how to better detect and treat depression, for example. Informal, ongoing contacts and doing well with referred patients will increase your credibility, and they soon may be asking for briefings! You can anticipate providing some in-services, but initially let them come to you.

## **The Principle of Relentless Follow-up**

PCMs and other healthcare providers are extremely busy. They see patients in 10- to 15-minute blocks, all day long. Details and requests from every sector inundate them. In this atmosphere, you must be extremely persistent about follow-up with each PCM. Committing to same-day feedback (i.e., the PCM gets feedback the same day you see the patient) will further this goal. Preferably, and especially early in the integration effort, feedback should be face to face. If the PCM is not in the office, leave a note with a consultation report indicating your wish to discuss the patient the next morning. ***The intent of relentless follow-up generally should be to reduce the PCM's burden of care.*** If you track down PCMs only to give them numerous extra tasks, their avoidance behavior will become increasingly refined!

## **Mimic the Work Pace**

The pace of work in primary care is a major issue in whether you overcome initial skepticism and become part of the team. Healthcare providers have a consistent stereotype about mental health providers. Specifically, they are amazed at the length of mental health visits. Spending 50 minutes with a patient in primary care is a rarity. They see the longer time of mental health sessions as a form of proof that healthcare providers can't possibly address these issues in a 15-minute visit. You must adapt to this faster pace by scheduling much shorter visits (15 or 30 minutes, maximum), not only to "fit in" to the culture, but also to show that very short consultation visits can produce effective interventions. Healthcare providers are much more likely to see your recommendations as feasible when they discover that powerful interventions can come out of very short visits. This also applies to "curbside consults." Unlike specialty mental health care, where we may see a patient for an hour before feeling comfortable providing a clinical opinion, be prepared to get a brief version of a presenting problem, make a gross assessment or differential diagnosis, and then make a recommendation to the PCM.

## **Be Available At All Times**

It is important to reinforce healthcare providers in thinking of using your services at any time. This means encouraging “on demand” telephone consults with them at any time during the workweek. *It is especially useful to carry a pager, periodically send memos reminding providers of your availability, and provide a specific way to make contact.* When that pager goes off in the middle of a therapy session in your regular mental health office, the goal is to pick up the telephone and make immediate contact when doing so is reasonable. Often, this results in resolving some clinical question in two to three minutes, or agreeing to contact the PCM at the end of the therapy session. At other times, you may schedule a special, emergency session on top of your normal consultation schedule. In certain cases, having an “on-demand” consultation service may be the most effective way to integrate. Whatever form the on-demand service takes, its primary goal is to take care of a problem whenever a PCM makes contact. If the PCM has a good experience in reaching out, he or she is much more likely to refer other patients to you.

## **Be a Visitor—and a Peer**

It is important that the label “MD” not intimidate you. Be prepared to stick with a professional opinion when pushed by a doctor, or step forward and make your opinion known, even if it might elicit a respectful disagreement. Address providers by first name, or adopt the culture of that particular clinic. (Ask what they prefer you call them in the clinic.) Be ready to learn the lingo and practices of a PCM. Express professional opinions openly and candidly. Candor does not mean being openly critical of a PCM’s care. It means entering into a dialogue that, at one level, addresses a patient-care dilemma and, at another level, shows other providers that you “belong.”

## **Avoid Starting Your BHC Service in Internal Medicine**

Many AFMS locations have more than one clinic for primary care. Several also include internal medicine clinics as primary care sites, with panels of enrollees. Although an internal medicine clinic, in general, is an optimum site for BHC services, because of the condition types that prevail and the likelihood of multiple, co-occurring conditions, it can be a very difficult environment to navigate as you begin to hone your BHC skills. Many Air Force BHCs have cautioned against integrating into internal medicine until they have had ample opportunity to practice using this innovative model in traditional primary care. Once you have mastered the model and skill set, the transition to internal medicine is likely to be much smoother and more successful for both you and your patients! However, if you find yourself initially integrating into internal medicine, seek out mentorship and consultation specifically from a trained BHC who has worked in this environment. They will be uniquely able to guide you on necessary tweaks to the model.

## **Ideas for Getting Started During the First Three Months of Consultation**

- Set up a meeting with the clinic chief to discuss the service and ways to educate providers and technicians about it.
- Set up a schedule for 30-minute appointments.

- Walk around the clinic at the beginning and/or end of the day, or before a staff meeting. Talk with the providers and distribute a written announcement of your practice.
- Attend staff and provider meetings.
- Provide legible, same-day, written and verbal feedback on patients.
- State that you have an open-door policy.
- Prepare a handout showing your pager and voice-mail numbers in large, bold print.
- Suggest that the medical receptionist place the announcement on a provider bulletin board.
- Accept an emergency, and work late.
- Present a requested talk and/or provide brief, practical, and instructional handouts for patients or providers.
- Write a newsletter to build interest in your overall program, or clinical pathways that you establish.
- Consider using posters in PCM exam rooms or waiting areas to educate patients. (See Appendix 15 for a sample poster.)
- Use a brief screening tool (e.g., PHQ-2; Kroenke et al., 2003) on a poster, so patients can identify their own need for your services to their PCMs.
- Expect low patient volume initially and for several months after establishing your service.  
***Be creative, continue to market yourself, circulate, simply be there, and be available!***  
Don't get discouraged, and go back and sit in your office in the mental health clinic. Use the PHA process to start identifying potential patients; begin using brief, routine screens that the techs can administer to identify potential patients. Hang in there!
- If you don't have a full schedule, walk around at the beginning of your clinic time to let providers know that you're available that day.
- Periodically, highlight a particular BH issue to remind providers of the variety of problems with which you can help them. For example, pass out a flyer each month about a different problem, such as weight management, diabetes, etc...whatever you believe are high-frequency problems that providers might not routinely think of sending your way. If you don't have a flyer, do this verbally: "I'm available today if you have any patients with BH needs. In particular, I'm asking providers to keep me in mind for patients with sleeping problems."
- If particular providers aren't sending you referrals, touch base with them. Find out why, and address it. For example, you would want to know if they are telling patients that a mental health counselor is available in the clinic for them to talk to about their issues! Be prepared to talk with providers about ways to present BHC services to patients. This also underscores the importance of letting providers know, when you first start up the BHC service, what your role is (and is not), how you work as a consultant to PCMs, and how your services differ from traditional mental health. The better PCMs understand what you do (and don't do), the better they can describe the service to their patients.

## WHAT ELSE YOU NEED TO KNOW BEFORE STARTING IN PRIMARY CARE

Although this manual has provided both an overview of the model and details about how to practice using it, most behavioral health providers have not had any clinical experience working in a fully integrated model of care. ***Because practice elements and skill applications in this model are unique, we consider clinical training a must before integrating into primary care.*** This is the ***only*** model that the Air Force has thoroughly scrutinized, clinically and legally. Without adequate training and adherence to the model's guidelines you are likely to be at greater risk and liability. Clinical training is available and accessible through Air Force BHOP program manager.

The goal of the training program is to create a set of standard service philosophies and approaches that all sites can apply consistently. The underlying philosophy is that all behavioral health providers can benefit from systematic exposure to and training in core service philosophies, practice-style adjustments, and administrative policies and procedures. Further, the program emphasizes that the best results occur when an identified "expert" or "mentor" proctors providers in both content (didactic) and skill-based (guided skill acquisition) training. Consequently, this program relies on the identification and training of local BHC "experts," who can function as both mentors and role models. (See Appendix 17 for a BHC mentor job description.)

The BHC training program has three major components:

- Phase I Preparatory training (manual review, didactic training and academic detailing, and demonstrating or acquiring prerequisite knowledge and skills)<sup>7</sup>
- Phase II Direct clinical-skill training, assisted by a core-competency feedback/mentoring process (The next section describes the skill-based training.)
- Phase III Continued consultation and mentoring (via telephone, e-mail, or additional on-site consultation with a BHC mentor). Additional reading to further your primary care skills (see reference list at the end of the manual for additional books and articles related to integrated primary care).

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<sup>7</sup> Most of Phase I training can be accomplished through this manual and a review of the BHOP Best Practices videotapes. Potential BHCs can review the prerequisite knowledge and skills using a self-assessment, and discuss them with a BHC mentor, to determine whether additional training would be helpful or necessary prior to Phase II. In addition to this BHC-specific preparation, core clinical skills should be considered prerequisites for working as a BHC. These include a solid foundation in behavioral interventions such as diaphragmatic breathing training, relaxation training, sleep hygiene and stimulus control for sleep, and behavior-change plans. Providers not trained in behavioral or cognitive-behavioral techniques should seek such training and supervision, in addition to BHC training.



## PHASE II: SKILL-BASED TRAINING IN CORE BHC COMPETENCIES

The basic philosophy of this training is that supervised clinical practice with a local expert, who also acts as a proctor and mentor, best develops BHC core clinical competencies. The goal of this phase is to help new BHC providers acquire the skills and abilities needed to successfully practice in primary care. This involves exposing new BHC providers to core clinical competencies first modeled by a BHC mentor. Then, a process of ongoing, *in vivo* observations, organized around specific competency feedback, teaches and makes these skills permanent. This process allows the systematic acquisition and assessment of core competencies; most importantly, it is similar from site to site.

The key material support for this phase is the BHC Training Core Competency Tool (see Appendix 18), which describes the basic consultation skills needed for successful BHC practice, along with a skill-specific rating system.

### Structure of the BHC Skill Development Program

Ordinarily, you will start Phase II of BHC training after you have successfully completed all recommended aspects of the didactic and academic-detailing program. Your BHC mentor must determine whether you are ready to begin supervised practice. If so, it should follow this structure:

- At the outset, arrange a four-hour block of time in your daily practice schedule for supervised patient visits. This block of time should be divided into 30 minute appointment slots. Typically, you will need a minimum of four supervised practice periods to achieve minimum competency levels.
- During the first one or two practice periods, your mentor will take the lead in patient contacts and model desired clinical skills. After each case, there will be some focused discussion about what he or she modeled. Then, for at least the last two practice sessions, you will reverse roles. You will take the lead, while your mentor observes and completes the Core Competency Feedback Tool for that practice session overall. Again, some focused discussion will occur after each case. At the end of the practice period, you will receive 30 to 60 minutes of feedback, which your mentor can organize around the assessment tool.
- After each supervised practice session, your mentor will provide feedback on whether you are ready for independent practice. Some BHC providers achieve this status in one or two practice sessions, while others take five or six. The average number of supervised practice sessions is four.<sup>8</sup>
- Your BHC mentor will continue teaching and supervising through regular consultation, as appropriate. This will be linked directly to quality indices that each newly trained BHC should be encouraged to monitor locally, or with the aid of the BHC mentor.

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<sup>8</sup> Many BHCs will receive training as part of their clinical psychology or social work residencies. Each residency site has determined training duration and intensity, which may not reflect the amount of training described in this manual. In addition, externship sites may differ from internship training based on provider's skill level. The critical factor is mastery of the competencies described in the core competency tool.

It can be useful to approach supervised practice with six, broad skill sets in mind:<sup>9</sup>

1. Clinical practice
2. Practice management
3. Consultation
4. Charting/documentation
5. Administrative functions
6. Team functioning

## **The BHC Training Core Competency Tool**

The BHC Training Core Competency Tool (Appendix 18) can help your mentor provide organized feedback during the supervised clinical-practice and mentoring phases of training. It also allows you to directly observe areas of relative strength and weakness in your practice. Finally, systematic use of the tool provides important progress information to both you and your BHC mentor during the supervised-practice and mentoring phases.

### ***How the Tool Is Organized***

The tool is organized around six broad skill sets: clinical practice, practice management, consultation, providing documentation and feedback, administrative functions and team functioning. BHC mentors can readily observe each competency during clinical training, and the tool can provide opportunities for written and verbal feedback to BHC trainees. Each competency has a number of defining sub-elements. These sub-elements help create behavioral anchors for a competency rating. In other words, all the specific practice sub-elements listed under “clinical practice” define competence in clinical practice. Each sub-element has a rating scale of 1 to 5 (a “1” means skill development is needed, and a “5” means a very high level of skill is present). This rating is how BHC mentors organize feedback. A “comments” section under each competency allows BHC mentors to make notes about strengths and weaknesses observed during supervised practice or ongoing mentoring.

### ***Completing the Tool***

Generally, your BHC mentor will complete a Core Competency Feedback Tool during each supervised practice session. Normally, the best strategy is to use the “comments” section to write notes as events occur during a session, and then complete the competency ratings at the end. The notes become a primary source of rating data for your mentor. The most effective notes describe specific behaviors, rather than unobservable events (i.e., comments such as “BHC said or did ‘x’” can be very useful for feedback).

### ***Organizing and Providing Constructive Feedback***

The tool has two primary purposes: 1) to give you specific feedback about areas that need skill development, and 2) to proctor you for independent clinical practice. ***A new BHC should obtain a minimum rating of “3” in all sub-elements, on two successive practice or rating sessions. The BHC mentor should communicate this expectation clearly to the new BHC before starting supervised clinical practice.*** When reviewing the tool at the end of a session,

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<sup>9</sup> This is a breakdown of larger skill sets on the Core Competency Tool.

your BHC mentor should be clear about each of the sub-element ratings and its basis. This is also a “learning moment” where teaching strategies, such as role-playing or guided rehearsal, can be quite useful.

### **PHASE III: CONTINUED MENTORING**

Although no specific schedule of continued consultation is required, many BHC mentors have used regularly scheduled, monthly consultations, coupled with on-request site visits. They have also submitted videotapes, with review and feedback, which seems to be an effective, efficient way to convey additional, personalized feedback on clinical skills. Mentors can give most consultations on BHC practice management via the telephone or e-mail correspondence. For those BHC trainees with ratings lower than desirable in certain areas, we highly recommend additional training or consultation, which may require more than telephone conversations or e-mail correspondence. In general, once you have established your practice and achieved adequate ratings on all core competencies,, you are considered ready to practice as an independent BHC. At this time, both you and your mentor should feel confident that you have met or exceeded all requirements in the BHC Job Description (see Appendix 4). Although a BHC could meet all requirements without going through training and mentoring, it would be more difficult to show evidence of having attained them in order to obtain BHC credentialing.

### **BHC CREDENTIALING**

Once your BHC mentor has determined that you adequately demonstrate the required core competencies for independent practice as a BHC, you will receive a certificate documenting your training completion. Once the BHC credentialing process is in place, you will be able to apply for BHC credentialing through your MTF. Additional information regarding BHC credentialing will be disseminated through the BHOP program manager and the specialty consultants as the process is implemented. Please direct questions about BHC credentialing to the BHOP program manager.

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